Maternal and Child Health Services
Title V Block Grant

State Narrative for District of Columbia

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

These documents are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.
An attachment is included in this section.

E. Public Input

In past years MFHA has made the Title V block grant application available for review at the public libraries. Feedback on perceived needs and priorities was obtained at conferences and through focus groups. This year the senior deputy director presented the idea of establishing a maternal and child health advisory committee as a mechanism for institutionalizing public input for MFHA programming.

Nearly 50 stakeholders (local hospitals, the primary care association, community-based organizations, and members of the CSHCN advisory group) attended a three-hour open forum on June 14, 2006 to hear MFHA representatives describe sources of funding, current programs, and the regulations for the Title V block grant. Various ideas for the structure, scope, and composition of an advisory group were discussed. Needs included: more information on how Title V and other grant funds are used, the proportion of funding allocated to personnel costs, and the effects of the Department of Health's programs and interventions.

Several next steps were agreed to, including making sections of the 2007 block grant report and application accessible to advocates, disseminating information on evidence-based practices, and investigating convening a meeting with stakeholders and government agencies that service the MCH population. MFHA management will continue to develop plans for convening an advisory group in the next year.

/2008/ The former Maternal and Family Health Administration (realigned as the Maternal and Primary Care Administration -- MPCA) has conducted meetings with the following Advisory Groups during the reporting period: District's Healthy Family/Thriving Communities Collaboratives; the Children with Special Health Care Needs Advisory Board; the Men's Health Advisory Board; and the Women's Health Advisory Board. MPCA provided a draft of the 2008 Title V Application/ 2006 Annual Report to the advisory board members for their input. //

The groups raised critical health issues. Mental health was considered a critical issue. The groups agreed that major health problems included obesity, HIV/AIDS, nutrition, teen pregnancy, infant mortality, and preventive health care. When asked what the District Department of Health

(DC DOH) can do to improve services for mothers, children, and families and children with special health care needs, there were numerous responses, including increasing public knowledge of available services and providing clinics at more convenient times for families during the evening or on weekends. /2008//

/2009/ A Town Hall Meeting was conducted in May 2008 to solicit public input for the 2009 Title V Application. Participants validated proposed state priorities and provided testimony for additional needs for Children with SHCNs and provider education. An update of MCH efforts and utilization of grant funds was presented. Use of the exisitng Special Health Care Needs Advisory Board will help CHA: to review current state priorities;to identify gaps in services within the District's health care delivery systems; to identify who in the communtiy can fill gaps; monitor state performance. // 2009//

/2010/ A Community Forum was convened on May 6, 2009 to seek input on DC Health Priorities. More than 60 participants attended, representing 9% parents, 39% providers, 27% advocates, 4%subgrantees, and 21% government. Dr. Nathaniel Beers opened the session with a welcome and overview of the Title V grant including objectives, funding requirements and current programs supported through Title V funds. Participants were requested to select a specific focus group: CSHCNs, Child and Adolescent Health or Perinatal and Maternal Health. Focus Groups were instructed to identify gaps in services and identify the gap source: funding, providers/programs, policy, and/or regulation/law. There were several primary themes that emerged from the three focus groups:

1) Health Literacy - participants' cited the need for inclusiveness of education to both mothers and fathers, teens, providers, and school officials. Educational topics: Lead, medications, teen health, sexual health, new contraceptives, education to high risk moms (PIHB emphasis), and MCH and disaster planning (advised H1N1 disaster plan).

2) Provider/Services Access - the gap issues included an insufficient number of oral health, mental health, and special needs health care providers and rapid access to providers (school health integration 2010). The participants also stated that there are limitations or caps on services for special needs children; need for earlier assessment of children, including; lack of after school and summer programs for children with special needs; and difficulties in navigating the health care system (DC Parent Information Network). Need for services/programs to address youth violence. (2010 funded)

3) School Health -- the participants stated that there is a need for coordination within the school health program. The gaps include: lack of a single point of contact, asthma health plan for children with asthma who have a prescribed inhaler or other medication (exists), lack of oral health assessment, limited or no services for children with Alliance health coverage for mental health and substance abuse, hearing and speech; and services for children out of school (School Health Nurse Integration 2010)

A summary of Focus Groups recommendations included:
1)Conduct a Needs Assessment (in 2010)
2) Expand breast feeding trainers to support hospitals;
3) use of peer counselors for teen outreach and various media to deliver health messages, such as texting, Face Book, web sites;
4) School health services need a comprehensive set of rules/policies that encompasses all services in schools.
5) Make health fairs more youth oriented because teens will seek testing services and advice in venues that are not focused on specific diseases, such as HIV/AIDS, STDs, pregnancy. Increase the number of health fairs during school hours or locales where teens congregate.
6) Develop outreach and services for children and teens out of school, with a focus on expelled children. and

7) Meet with principals to explore how to increase access and education to teens, teen parents.

A Summary of Findings is attached.

There were 28 evaluations of the meeting returned (48% return rate). The results show that 93% were satisfied or very satisfied by the meeting. Similar meetings should take place at least twice a year (41%).

CSHCN Advisory Board reviewed/commented on the Title V 2010 application. TA/current programs emphasize needs. //2010//
An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2008/ The 5-year needs assessment provides both recent and longer-term trends data on MCH topics. It also provides a snapshot of the District of Columbia's demographic and socioeconomic characteristics. The assessment is used to assist planners and program staff to prioritize program and population needs based upon the data available.

During 2008, MPCA plans to involve service providers, community groups and health planners in the development of the 2010 needs assessment report. Also, MPCA officials will have an opportunity to discuss needs, problems, and priorities of the MCH populations that are utilizing the District's health care delivery system. Ultimately, MCPA will develop priorities and recommendations to address the most pressing concerns and develop ways to reduce disparities and poor health indicators. The needs assessment report should be widely circulated among stakeholders and placed on the DC DOH website for public comment. At the end of the process, findings, results, and outcomes of activities conducted during the year would be incorporated into the final needs assessment report. //2008//

//2009// The Community Health Administration (CHA) recognizes the HRSA mandate to have a 5-year needs assessment in 2010. CHA also realizes that a needs assessment should be ongoing, and should not be confined to the constraints of only every 5 years. In order to best fulfill this federal mandate, CHA has recognized the need to outsource the work effort to conduct the 5-year Title V Needs Assessment. CHA is finalizing a scope of work for a Request for Proposal (RFP) to be issued in late fall 2008. The scope of work includes but is not limited to:

1) Development of a project work plan.
2) Convene stakeholder meetings that include service providers, community groups, consumers and families and health planners in the development of the 2010 needs assessment report.
3) Interviews with DOH and other District officials to discuss needs, problems, and priorities of the maternal and child and special health care needs populations that utilize or need to access the District's health care delivery system.
4) Review historical data to support information collected during interviews and stakeholder meetings.
5) In collaboration with CHA, the vendor will develop a list of priorities and proposed recommendations to address the critical success factors or imperative concerns.
6) Identify and propose ways to reduce disparities and poor health indicators.
7) Develop and implement an Assessment Report distribution plan that will foster public input.
8) Submit a Public Input report.
9) Submit a final Needs Assessment Report that includes the process, findings, results, and outcomes of activities conducted during the year. Hard copies and an electronic copy will be made available in accordance with Title V application requirements, including required timelines.

CHA will assist with the circulation of the Needs Assessment Report through placement on the DC DoH web site for public comment as well as notification of its availability for review and comment in the weekly published Funding Alert.

Focus areas for the needs assessment should inlcude addresing Homelessness in DC, Violence and Injury Prevention, Infant mortality, data collection problems especially mental health data, as well as assessing health disparities.

CHA seeks a vendor with the corporate qualifications that demonstrate, at a minimum, capabilities in health care, strategic planning, focus groups, and analysis and planning. The vendor staff is expected to have the experience, education and skills to effectively and efficiently perform the tasks required in the scope of work. CHA Grants Management staff will work in concert with the vendor to ensure compliance and completion of the scope of work within the proposed and approved timelines.//2009//

/2010/ Community Health Administration (CHA) developed a scope of work for the Needs Assessment consistent with the tasks described in the 2009 Title V Application. CHA submitted the scope of work to the DC Office of Contracts and Procurement (OCP) for review and preparation into a Request For Proposal (RFP) standardized format. Interested vendors were expected to submit their responses by June 5, 2009.

The application review process will include, but is not limited to, critique and scoring by qualified reviewers. CHA received eight applications from various types of vendors including academic and community based organizations. Selection criteria include the vendor's technical approach, technical expertise, and past performance as well as cost proposal. A copy of the Needs Assessment Request for Proposal (RFP) is attached.

InterGroup Services (IGS) was awarded the contract to perform the needs assessment. Principle investigators include Douglas Munro, PHD, Presidnet and Joseph Cooney, Director of Research. IGS has performed similar work for Prince George's County Commission on Children, Youth, and Families and an assessment of the Needs of Toddlers and Young Children in Baltimore County. Mary Frances Kornak will be the DOH Contracting Officer's Technical Representative (COTR). The scope of work includes an assessment of internal MCH capacity through the CAST V Capaicty Assessment Tool. Holly Grason, an expert in CAST V, will facilitate. Key informant inteviews and focus groups with consumers, stakeholders, and organizations will comprise the community assessment component of the needs assessment that will discuss needs, problems, and solutions to access the health of the MCH population.

A draft needs assessment will be distributed prior to convening an MCH stakeholders meeting to facilitate the identification of new MCH priorities for the next 5 year period. A final report will then be submitted to CHA to be included in the next application. //2010//

An attachment is included in this section.

III. State Overview

A. Overview

The District of Columbia (DC) has a unique status as the nation's capital, and serves the multiple roles of a city, county and state. The District consists of an urban land area of 63 square miles. 57% of the land base is tax-exempt, much of it owned by the federal government, and 41% of the assessed property value is exempt from property taxes, factors that impact upon the resources available to the District government for services to residents. Although DC residents elect a mayor and city council, they do not have voting representation in the US Congress, which has exclusive authority over legislative acts, including those pertaining to the budget. This status, combined with limitations of the local government's authority to tax federal and other property and incomes of commuters, severely limits the availability and allocation of resources.

The District is divided into 8 wards--subdivisions on which political representation is based and public services are administered. Voters in each ward elect a city council representative, and 4 members are elected at-large. As described in the needs assessment section of this application, socio-economic indicators, racial and ethnic composition and health outcomes vary widely across the 8 wards.

The US Census estimated the 2004 population at 553,523, down from the 572,059 count from the 2000 census. The District of Columbia is a majority (60%) African American city. Information from the 2003 American Community Survey indicates that 30% of the population is white, 3.5% is Asian/Pacific Islander and nearly 10% is Latino. Approximately 15% of the population is foreign-born, with 18% of the household population over age 5 speaking a language other than English at home.

/2007/ The District successfully challenged the 2005 Bureau of the Census estimate, which on July 21, 2006 was corrected to to 582,049. The revision marks the most significant increase in the District's population since it peaked in 1950 at 802,178. //2007//

The District is characterized by a high rate of poverty--nearly 20% of individuals and 18.5% of families. Median household income and median family income are $42,118 and $50,243 respectively, lower than the US medians of $43,564 and $52,273. And more than 1/3 (35%) of the District's children are members of families living below the federal poverty level (31.3 -- 39.1, 90% confidence intervals). The most recently compiled data on the District's public school population show 84% of the enrolled students are African American and 9.7% are Latino. 64% are low income and 19% are enrolled in special education.

In addition to the high poverty rate, inequality and the concentration of poverty have increased over the past decades. A comparison of pretax income data from the 1970s, 80s and 90s found that the income gap between the highest and the lowest income quintiles was not only great but also growing. The average income of the top 5th of the District's households -- $186,830 in 1999 -- was 31 times higher than the average income of the bottom 5th of households --$6,126. This gap is as great as or greater than any of the nation's 40 largest cities. During the boom years of the 1990s, average income for the highest quintile increased 36% (adjusted for inflation), but only 3% for the bottom quintile.

/2007/ Analyses by the DC Fiscal Policy Institute indicated that income inequality is great in the District and has increased over the past decades. Income among DC's poorest families remained virtually unchanged between the 1980 and the 2000 census when the average income of the bottom fifth increased 3% from $12,300 to $12,700. In contrast, the average income of the richest fifth of families increased 81%. As a result, the income gap between DC's high-income and low-income families widened significantly, as did the gap between wealthy and middle-income families. In 2000 the richest 20% of District families had incomes 12.4 times as large as the average income of the poorest 20%, up from a ratio of 7.1 in 1980. //2007//

Poverty in DC has increased over the past decade but had become more concentrated in certain census tracts. From 1990 to 2000, the number of residents living in extreme poverty tripled, reaching 66,000, and the number of high-poverty census tracts in the city rose from 36 to 43. The number of extreme-poverty tracts more than doubled, rising from 10 in 1990 to 23 in 2000. 24% of poor residents lived in high poverty tracts in 2000 compared to only 9% in 1990. The majority of these tracts are located east of the Anacostia River (www.fanniemaefoundation.org/programs/pdf/Housing_in_the_Nation_2003_ch7.pdfAccessed June 5, 2003).

The District, which currently ranks 31st among states in the nation for maximum TANF benefits, provides lower cash assistance to households with no other income than neighboring Maryland (21st) and Virginia (29th). Over the past 15 years, the maximum benefit level for TANF recipients with no other income has dropped by about 40%, after adjusting for inflation. The current maximum TANF benefit for a single mother of 2 children is $379 per month, or $4,548 per year--only 29% of the federal poverty level! Considering additional income from food stamps, the annual income of a TANF family of 3 is just $750 per month, or about 60% of the federal poverty level.

/2007/ TANF benefits increased 7.5% effective July 1, 2006. Approximately 45,000 persons in 15,614 households receive cash assistance benefits in the District. Payment for a family of three increased from $379 to $407. A comparable family would receive $490 in Maryland and $389 in Virginia. TANF participation in the District is at its lowest level since the 1996 welfare reform law went into effect. //2007//

The metropolitan region is experiencing economic growth and an increase in jobs, but the benefits are concentrated in the suburban jurisdictions. Even jobs generated in the District disproportionately benefit suburbanites. Unemployment has increased over the past year, with the most recent figures (preliminary February 2005) showing an official unemployment rate of 8.2%, varying from 2.8% in Ward 3 to a staggering 15.4% in Ward 8.

One manifestation of extreme socio-economic disparities is the increase in homelessness. According to a HUD report, the District ranked 1st among 13 jurisdictions in the prevalence of homelessness--defined as persons living in shelters--with a point prevalence of 1.4%, or 7% of poor persons. When estimates include persons living in or awaiting transitional housing, the prevalence increased to 2.2%. Average length of stay in shelters was 87.5 days. The number of homeless women with children also increased with more than 150 typically awaiting placement at any given time. Increases have been attributed to several trends: the decline of affordable housing and reduction in public housing units, breakdown in public services for substance abusers and mentally ill persons, and cuts in public assistance and welfare to work policies. The most recent survey conducted by the Metropolitan Washington Council of Governments found an increase of 8.8% (8977) in the number of homeless persons in DC from 2004.

/2007/ The 2006 point-prevalence survey of homeless persons conducted by the Metropolitan Washington Council of Governments found a 5.6% increase in the District from 2004, a current rate of 10.7/1,000. Slightly more than one-third is defined as chronically homeless. Approximately 33% of the District's homeless are persons living in families http://www.mwcog.org/uploads/pub-documents/8FpWXg20060615080733.pdf. //2007//

Another analysis by the DC Fiscal Policy Institute found that the number of low income persons increased while the number of affordable housing units declined: In 1990, there were 47,000 renter households with income below $20,000, and 43,000 apartments affordable to them ($500 per month), a shortage of 4,000 units; by 2003, the number of low-income households had increased to 55,000 while the number of affordable rental units had fallen to 31,000 -- widening the affordable housing shortage to 24,000 units.

Of the District's population 35% spends 30% or more of household income on rent and utilities, a threshold at which families are considered likely to be deprived of other necessary goods such as food. Only 41% of District housing units are owner-occupied, ranging from 21% in Ward 8 to 62% in Ward 4. Furthermore, the most typical household composition is the 1-person household--44% of all households. 13% of households are female headed with related children. 13% are married couple households with no related children. The prevalence of female householders with related children varies from 2.1% in Ward 3 to 33% in Ward 8.

The extreme disparities in income and wealth overlaid with the long-term impact of racism, all concentrated in a small geographic area, without full political sovereignty, present formidable challenges to protecting and improving the public's health.

Since the mid 1990s, the way in which health services to the poor are financed and delivered has undergone many changes, not always in a linear fashion and generally without the inclusion of maternal and child health advocates in the planning process. First was the change from fee-for-service to mandatory managed care for the TANF Medicaid population, followed by an expansion of eligibility based on the SCHIP program. In 1999, the District consolidated its public hospital and network of ambulatory clinics into a single entity, the DC Health and Hospitals Public Benefits Corporation. 3 years later that entity was abolished.

In June 2001, the District, then operating under the authority of a federally-appointed, 5-member Financial Responsibility and Management Assistance Authority established in 1995, closed inpatient and emergency services at the city's sole public hospital, DC General Hospital, and transferred the management of the hospital's ambulatory clinics and community health centers, which along with the hospital were operated under the auspices of the DC Health and Hospitals Public Benefit Corporation, to the private sector. Another umbrella organization, the DC Health Care Alliance, was created to fund and manage the privatization of safety net health services. Before the kinks in the restructured safety net system--the Alliance--were worked out, arrangements began to deteriorate due to the financial instability of the prime contractor's parent corporation. In November 2002, the National Century Financial Enterprises--an Ohio lender that supplied virtually all of the Greater Southeast Community Hospital's (GSCH) cash--collapsed, causing the hospital to immediately close pediatric inpatient and other services, reduce staff and take other crisis measures, and the parent corporation, Doctors Community Healthcare Corp. which had purchased the GSCH when it was forced into bankruptcy several years ago, eventually filed for bankruptcy itself.

The GSCH, the only acute care and emergency facility located in the southeast quadrant of the city, has remained open despite financial and accreditation problems. The Department of Health (DOH) assumed management of the Alliance, stepping into the administrative role previously played by GSEH. The extent to which the restructuring of the safety net has benefited those who use the system is still being debated. The Alliance is considered to benefit small not-for-profit, neighborhood based clinics and their patients--clinics that are not part of the Medicaid MCOs' networks. These clinics provide culturally and linguistically appropriate care to many of the city's residents who are uninsured but not eligible for Medicaid/SCHIP. In particular, Latino residents have voiced their support for the Alliance at various community forums. More than 20 specialty clinics and health services remain available on the DC General campus, operated by Alliance subcontractors--Ear, Nose, and Throat (ENT) Clinic, Cardiology Clinic, Pediatrics Clinic, Dental Clinic, Gastro-Intestinal (GI) Clinic, Obstetrics and Gynecology Clinic, Surgery Clinic, and Urology clinic.

In October 2003 The Henry J. Kaiser Family Foundation released the findings from the DC Health Care Access Survey, 2003, a telephone survey of a representative sample of 1581 adults. Findings confirmed that 2 characteristics shape access and health status in the District. The population is majority (72%) "minority" (African American, Latino, Asian/Pacific Islander and other). And 36% of the entire population is low income (less than 200% of the federal poverty level, $30,520 for a family of 3). Latinos (55%) and African Americans (38%) are much more

likely to be poor than are whites (20%). The report concludes that the Latino population is particularly vulnerable to lack of access to health services.

Due to the expansion of public programs in recent years, the DC population now has 1 of the highest rates of health insurance coverage in the US. 91% of those age 18 -- 65 have some form of health coverage, 70% employer based insurance, 11% Medicaid-SCHIP, 5% other and 4% DC Health Care Alliance. (Although the Alliance is not strictly speaking an insurance program, enrollment in the program enables beneficiaries access to Medicaid managed care-like services at no charge.) Only 5% of women in this age group lack some coverage. But although a relatively low proportion of the population lacks health insurance, the impacts vary. For example, 32% of Latino adults lack insurance, compared to 10% of African Americans. Other findings include:
- 9% of the population either relied on an emergency room or reported no regular source of care, with 24% of Latinos being in this situation.
- 36% of uninsured persons rely on emergency room (21%) or had no regular source of care (15%);
- 45% of the uninsured did not have a medical visit in the last 12 months;
- 38% of all Latinos had no medical visit in 12 months;
- Residents (24%) believe HIV/AIDS is the most critical health issue in the District;
- 40% of Latinos report having a problem communicating with providers due to language barriers;
- Although 79% of residents rate their overall experiences in the health care system as excellent or good, the elderly, white and higher income residents report more positive experiences than others.

Medicaid participation is high in the District, due to the high prevalence of poverty. Approximately 24% of the entire population receives Medicaid-SCHIP benefits. The District operates a combined Medicaid-SCHIP program, with eligibility covering up to 200% of the federal poverty level and including parents living with children under age 22. Presumptive eligibility for pregnant women provides coverage for this population, although many otherwise eligible persons are excluded due to their immigration and naturalization status. There are currently 3 managed care contractors that provide services to the TANF and TANF-related, and SCHIP beneficiaries. Another contractor provides carved-out services to children who qualify for SSI and Medicaid. Families may elect to receive fee-for-service Medicaid for these children.

/2007/ The recently adopted FY 2007 budget provides for expanding Medicaid for persons under 21 years of age from 200 to 300% of FPL. Pregnant women will be covered as well. It is estimated that up to 1,000 individuals will be newly eligible. The expansion must be approved by CMS.

In August 2005, the Department of Health announced it would incorporate performance-based payments into its contracts with managed care organizations (MCOs) serving Medicaid enrollees. The three Medicaid MCOs are now required to submit 41 Health Plan Employer Data and Information Set (HEDIS) measures with initial reports due July 2006. The District is currently developing its quality-based reimbursement system. It is expected that plans would be given capitated payments up front and, if they exceed performance measures, enhanced rates as bonuses. If a plan underperforms, it would be penalized. The current procedure in which beneficiaries who do not select an MCO are assigned randomly may change to one by which better performing plans received a greater proportion of assignees. //2007//

The DC Health Care Alliance provides health care services to approximately 26,400 uninsured District residents with incomes < 200% of the federal poverty level, and who are not eligible for any other health insurance coverage, including Medicaid. The Alliance is funded entirely by District funds.

The debate on how to finance and deliver health care safety net services in the District is far from over. It appears likely that within the next year, Alliance contracts will be aligned more closely with

Medicaid MCO contracts. Advocacy for a hospital to replace the DC General Hospital is very much alive. In 2004, the District entered into a MOU with Howard University Hospital to begin work for a new full service Level 1 trauma center with 200-300 beds to be constructed on the campus of DC General. Considerable debate about the feasibility of another hospital, and its effects upon other hospitals, particularly the floundering GSEH continues.

/2007/ The debate about the need for and how to finance a new hospital is continuing; the initial agreement with Howard University Hospital appears to have halted. A mayoral commission has been appointed to make recommendations. //2007//

In June 2005, the chair of the city council committee on health introduced legislation (B16-0348 Universal Healthcare Access Act of 2005) that would require the mayor to recommend within 6 months strategies to ensure universal access to health insurance by no later than December 2010. The bill, which is expected to be considered before the end of the 2005 session and is likely to be approved insofar as only 1 councilmember is not listed as a co-sponsor, lists strategies to include opt-in purchasing to the city's Medicaid program, insurance pools, medical savings accounts, or small employer buy-ins into the District's health insurance.

Mirroring the profound disparities in economic status and health indicators, the District's health care delivery system is 1 of extremes: 3 world class academic medical centers cluster in the northwest section of the city, yet 52% of the population resides in federally designated Health Professional Shortage Areas (HPSA). About 18% of the population lives in Medically Underserved Areas (MUA). Much of the HPSA has been designated as shortage areas for dental services and mental health services as well. According to an annual survey conducted by DC Primary Care Association, the primary care safety net consists of:
- 14 privately operated organizations, 4 of which are federally-funded section 330 community health centers. All together, the 14 entities operate 38 freestanding sites and 3 mobile units;
- 7 hospital affiliated clinics; and
- 3 school based clinics, 1 of which is operated by the Department of Health with federal Healthy Start funds and clinics operated by the Department of Mental Health (number not provided.)

The DC Primary Care Association analyzed the needs, capacity and demand for safety net services and concluded that the existing clinic system is not capable of meeting the demand for primary care services in accessible neighborhood-based settings. Often housed in inadequate physical space, with limited equipment and sometimes thin staffing, few offer the range of services required for adequate primary care. Additionally, linkages to secondary and tertiary care are too frequently tenuous. Moreover, the existing clinics are maldistributed across the city, with relatively few located in the lowest economic areas. DC Primary Care Association therefore embarked on a long term campaign to raise funds for the capital development of safety net clinics. Raising funds from federal, District and private grants and loans, and providing funds and technical assistance to safety net organizations are the initial steps. But assisting providers to expand and increase their own revenue streams is a primary strategy as well. Within the last year at least 4 private community based health centers have applied for and/or been granted federally qualified health center status and funding.

/2007/ In spring 2006, the DC Primary Care Association announced that Alvarez & Marsal and The Jair Lynch Companies were selected as development consultants to manage site selection and construction for its Medical Homes DC capital projects. To date, DCPCA -- through its Medical Homes DC initiative -- has awarded $1 million in District capital planning and development grants to seven local nonprofit community health centers for nine projects as part of an effort to provide health care to over half of DC residents living in medically underserved neighborhoods. Another $6 million in grants will be available later in 2006. Several health centers were awarded federally qualified health center status this year. //2007//

An analysis of the Behavioral Risk Factor Survey and hospital discharge data commissioned by the DC Primary Care Association and released in January 2005, confirmed that the adult chronic

disease burden is concentrated in low income zip codes of the city where there are fewer primary care providers. Furthermore, an examination of avoidable hospitalizations by age group and poverty rate of resident zip code during the period 2000 -- 2003 suggested to the researchers that due to the expansion of Medicaid and the establishment of the Alliance, the rate of avoidable hospital admissions declined to a greater extent in high poverty zip codes (43-59% below 200% of FPL) in comparison to zip codes with less concentration of poverty. The principal investigators, Nicole Lurie, RAND Corporation, and Martha Ross, Brookings Institution, also concluded from their review of these data that there was no evidence of an adverse effect of the closure of DC General Hospital in mid-2001.

/2007/ In 2006 legislation established the Office of African Affairs to assist immigrants with health, education, and job services. The District's African-born population increased approximately 40% in the 1990s, reaching 9,208 by the 2000 Census. Africans represent one-eighth of foreign-born residents, with Ethiopians constituting the largest group.

In September 2004 DOH published a report of a survey of the health status, risk behavior, and access to health care of the African, Latino, Asian and Pacific Islander and Caribbean immigrant populations in the District. Although it is not clear from the description of the sampling approach to what extent the results can be generalized, substantial numbers of immigrants were not obtaining basic preventative services. Of those sampled, 29% were uninsured. Nearly half of the women who responded had had a mammogram within the past 12 months, with higher rates among women from the Caribbean compared to Asian and Pacific Islander immigrants. About two-thirds of the women had had a PAP smear test in the past 12 months, with the lowest rates among Asian and Pacific Islanders. And 46% reported having an HIV test within the last 12 months, but 25% had never been tested at all. Among those not tested the most frequently given reasons were: lack of information about testing sites, no perceived need for testing, fear and cost. 79% were sexually active. Only 45.5% had seen or heard DOH prevention messages. //2007//

The District of Columbia Department of Health

The Department of Health (DOH), where the official Title V agency is located, became a cabinet-level department in January 1997. The FY 2005 operating budget of $1,637,183,303 supports 1456 FTEs. 2/3rd of the budget total is based on federal Medicaid payments ($951,289,000) and federal grants.

/2007/ The department operated in FY 2006 with an approved annual budget of more than $1.7 billion and 1,370 FTEs; 66% of the budget is from federal sources. Due to the unique relationship between the District and the federal government, Congress has oversight of and must approve the District's budget. //2007//

The director of the DOH reports to the deputy mayor for children, youth, families, and elders, a position created by the current administration to give more visibility and attention to services affecting this population. The Department of Human Services and the Department of Mental Health also fall within the purview of that position.

Gregg A. Pane, MD, MPA, CPE, FACEP, was appointed director of DOH August 2004. Dr. Pane has more than 20 years of executive level public health experience. He joined the District from the Henry Ford Health System, where he served as System Vice President for Clinical Quality and Safety and Medical Director for Public Policy Initiatives for 2 years.

DOH is responsible for Medicaid (Medical Assistance Administration), contracting with the private sector to provide safety net health services and managing the Alliance (Health Care Safety Net Administration), substance abuse (Addiction Prevention and Recovery Administration), environmental health (Environmental Health Administration) and licensure and facilities regulation (Health Care Regulation and Licensing Administration). Other components are: Emergency Health and Medical Services Administration, HIV/AIDS Administration, Primary Care and

Prevention Administration, Health Promotion Administration, and Policy, Planning and Research Administration.

Following his appointment, Dr. Pane continued on-going efforts to centralize support functions and flatten the organizational table. He has delineated 3 principles and 5 strategies to guide DOH. The principles are innovation, measurable results and absolute fiscal and ethical integrity. The strategies are neighborhood outreach and prevention; quality, safe and coordinated system of care; community preparedness; healthy environment; and making government work. Included in the neighborhood outreach and prevention strategy is the consolidation of the Title V-mandated 800 information and referral line with other departmental information services and the establishment of a community outreach team to coordinate and integrate various grants and programs. Outreach and prevention efforts are to focus on language access, health literacy and community partnerships.

The Title V-mandated telephone information and referral operation was consolidated with other DOH information services call centers and hot lines in the communications office of the director of the department. Staff is trained to respond to a broad range of calls. Callers who request the information about maternal and child health services are being re-routed to the 1-800-MOM-BABY HEALTHLINE; however there are reportedly many callers who hang up because of the automated prompts in place before one connects with a live HEALTHLINE counselor. As a result, opportunities to engage women who call the 1-800-MOM-BABY HEALTHLINE and probe about status of prenatal care, health insurance, or child care issues and to intervene with referral services or brief counseling may have been affected. Because the 1-800-MOM-BABY HEALTHLINE is no longer the first responder for Title V services, call volume has been reduced by more than 50%. For Title V reporting (Form 9), the calls reported are those that are received via referral through the centralized call lines and calls made to the direct line.

In the winter of 2000, under the leadership of the State Center for Health Statistics Administration, DOH completed the 2010 planning process. The final plan, which was released in September 2000, incorporates 20 maternal and child health objectives, 14 adolescent objectives, and 6 family planning objectives. The Maternal and Family Health Administration staff relied heavily on the performance measures required for Title V reporting, and consequently 13 of the 2010 objectives overlap with the Title V measures (http://dchealth.dc.gov/information/healthy_people2010/pdf/2003_2004bipfinal.shtm). In addition to the overarching objective of reducing the infant mortality rate, several focus area objectives are directly related to Title V performance measures: breastfeeding, childhood immunization, early entry into prenatal care, and asthma hospitalization. A biennial implemental plan for 2003-2004 has been published and a community forum was held in the summer of 2005 to inform stakeholders of progress toward the objectives.

A 5-year health systems plan to guide the certificate of need program continues to be developed.

/2007/ MFHA continued to participate in the DC Healthy People 2010 process. DOH has published several reports--Healthy People 2010 Biennial Implementation Plan Year 2003-2005, Biennial Implementation Plan Progress Report Year 2003-2005, and Mid-Course Revisions 2000-2005. A public forum was held in May 2006. This year MFHA reduced the number of objectives it will report on from 23 to a more manageable subset of 8; selection was based on the availability of current data and relevancy to programming.

A draft of the District's long-awaited health systems plan was completed in May 2006. The plan is based on Healthy DC 2010 objectives.

The DC Cancer Control Plan 2005-2010, released in May 2006, revealed that the incidence of breast cancer in DC (143.3/100,000) is considerably higher than the national rate (132.2). Mortality is high as well. Screening rates are higher in DC than nationally among age groups, African Americans and women of low education. In addition to increased screening,

recommended strategies focus on linking women to cancer care services.

DC has the highest rate of cervical cancer among states in the US, and the proportion of cases diagnosed in advanced and unknown stages is higher is DC than in other states. Recommendations include a public education campaign to increase awareness of symptoms of ovarian and endometrial cancers. //2007//

In 2004, the District passed legislation called the Language Access Act to increase access to government services and benefits. It requires government agencies to provide oral language services to limited English proficient persons, meaning persons whose primary language is not English as well as English speakers with low literacy skills. Each agency is expected to determine what type of oral language service (i.e. telephone language line, bilingual front-line staff) to provide by considering a number of factors, including the agency's size and the type of services it provides. Agencies are also required to provide written translations of vital documents into those languages spoken by the larger language populations served. Medicaid clients are being informed of their right to an interpreter (not necessarily a medical interpreter) in any native language, and translation of all vital documents in Spanish, Vietnamese, Mandarin, Amharic and/or Braille. Print materials are to be designed at a 5th grade reading level. The extent to which compliance with the law has been achieved has yet to be determined.

After forming several strategic partnerships, the DOH State Center for Health Statistics engaged in efforts to expand understanding of health issues among Latinos. Supported in part with a grant from the Centers for Medicare and Medicaid Services and consultants from the George Washington University School of Public Health and Health Services, the Council of Latino Agencies completed in 2004-2005 a household survey in Wards 1, 2 and 4 where the Latino population is concentrated. The interview was based on the Behavioral Risk Factor Survey items and adapted for the target population with input from a community advisory group, the Latino Health Care Collaborative, which continues to work on Latino health issues. In addition to the survey, the Council of Latino Agencies has recently published several reports based on analyses of secondary data to describe changes in the Latino population and to highlight disparities.

/2007/ In fall 2005, two committees--the Committee on Health and the Committee on Education--of the District Council (legislative branch) initiated hearings on the school health program. These hearings, combined with the work of advocacy groups, several of which were promoting the development of school-based health centers (SBHC), increased attention to the need to improve the school nurses program and has resulted in renewed interest, oversight, and funding for school health. In October 2005, the DOH was charged with developing a plan for a "coordinated school-based health service program". The project was assigned to the Maternal and Family Health Administration, Child, Adolescent and School Health Bureau. MFHA expended considerable resources on this effort throughout the 2006 fiscal year.

Staff conducted a needs assessment consisting of a review of existing reports of the DC Public Schools (DCPS) and the contractor for school nurse services, Children's National Medical Center; interviewed managers of various school-based mental health, substance abuse and health programs; and reviewed the literature on school health services. Service gaps and concerns were identified. A draft school health plan was published for public comment in January 2006. The following is a partial summary of the conclusions of the assessment.

There is no single document or collection of documents articulating the various statutes, rules and inter-agency agreements governing the funding and provision of health care services in public and charter schools. The complex governance and multiple institutional oversight of the school system including the Board of Education, DCPS administrators, the Council as well as the participation of other entities such as DOH, Child and Family Services Administration (CFSA), DMH, in the provision and oversight of health care services has resulted in an incomplete and at times inconsistent regulatory regime. The absence of a clearly articulated set of rules has created confusion and occasional controversy with respect to the provision of school-based services.

Since 2001, the Children's National Medical Center (CNMC) has operated the school nurse program under contract to the DOH. District law requires that all schools have a registered nurse available for a minimum of 20 hours per week. Among the 170 schools currently covered by the nursing program, 63.5% (108/170) receive 20 to 24 hours of registered nurse coverage per week while 36.5% (62/170) of the schools receive 40 hours of coverage each week. The average nurse-to-student ratio is roughly 700:1. Although this ratio meets the recommendation of the National Association of School Nurses and Healthy People 2010, it does not respond to variation in needs across schools. Consideration of needs includes: increased mainstreaming of medically fragile students; variation across schools in the numbers of medically fragile students--a factor not taken into account in calculating the nurse:student ratio; variation across schools in the prevalence of chronic diseases requiring attention from the school nurse; the lack of any school nurse coverage in more than 30 public charter schools; and the increasing demand for personnel to administer medication in the school setting.

The assessment concluded that much of what nurses perform during a typical school day does not require the level of a registered nurse. LPNs and other assistive personnel could generate letters, dispense medication, track down parents, and provide certain levels of care under the supervision of a registered nurse. The current staffing model based almost exclusively on RNs does not allow the flexibility to match the skills of caregivers with student needs. Although the authorizing statute prefers RNs, the law appears to allow the use of LPNs working under an RN to a much larger extent than presently utilized.

System-wide policies and procedures are not fully in place to a) alert the nurse services contractor about the expected case load of medically fragile children in a given school; or b) involve the nurse in the initial planning and coordination of care for these students; or c) ensure that a copy of the updated individualized health plan is maintained in the health suite or otherwise readily available to the school nurse.

CNMC hires a considerable proportion of contract personnel to staff its program with registered nurses. The fact that these practitioners are not employed by CNMC may affect continuity of care and adds complexity to program management and contract oversight.

In addition to the nurses' workload and staffing issues, the report noted problems with their work environment. No regulatory regime currently exists in the District to set and enforce minimum standards for equipping or operating these health care facilities. Currently, the space and quality of nursing suites vary widely from school to school. Some nursing suites lack running hot water and others have no phone. Many have no lockbox for the secure storage of student medication. Nearly half of the health suites are without routine online access to Web-based resources such as the DC Immunization Registry.

Another conclusion of the status report focused on the lack of standards or guidelines governing coordination among agencies and disciplines providing services in the schools. Proximity of nurses, school based health center (SBHC) practitioners, and mental health clinicians located in the same school would facilitate interdisciplinary collaboration, appropriate information sharing, and continuity of care. However, nursing suites, SBCH, and counseling rooms are not consistently co-located in the schools that provide these services. Additionally, the DMH operates programs in a number of schools, and a mobile dental services program circulates as well.

The degree of health information sharing among the different school-based clinicians (nurse, mental health counselor, nurse practitioner, dentist etc.) who may be seeing the same individual student varies from school to school and is often minimal. Forms to collect health information are not uniform system wide.

The level of coordination (e.g., follow up on referrals) between the school nurse and community-based specialty providers is reportedly limited. There is also need for clarity with respect to which

parties (school staff, nurses, or both) are responsible for updating and securely maintaining health care records in the school.

At present there is no formal coordination between CNMC nursing staff and the four SBHCs. A coordinated school health service program could in principle involve a single billing system for all school-based clinicians. Economies of scale could be achieved if all practitioners providing billable services could utilize the same system. Maximizing third-party reimbursement for services provided to the general student population would create a stable funding revenue stream available for continuing program improvement or expansion. Likewise, establishing a repository of electronic medical information accessible to the appropriate health personnel to facilitate continuity of care is more likely to occur under a unified governance structure for school health services than a fragmented system.

There is no formal relationship to date between school-based practitioners and Medicaid health plans covering a large proportion of the student body to coordinate services or for reimbursement of services. School-based Medicaid-covered services that qualify for federal funds include physical, occupational, and speech therapy, as well as diagnostic, preventive, and rehabilitative services. Presumably, school nurses could bill for providing certain services under the supervision of a physician or a nurse practitioner or when standing orders for certain Medicaid-covered services are on file. A clearly-stated and consistent policy has yet to be developed on this issue.

The poor oral health status of underserved children in the District was frequently raised in the course of assembling the school health plan report as an issue that requires immediate attention. SBHCs may provide dental care as part of an expanded scope of service or oral health assessments as routine care.

The nursing service program administered by CNMC has never undergone a comprehensive evaluation. The needs assessment, therefore, recommends an evaluation of the entire program, which should include an examination of the interface and linkages between SBHC and school nurses including questions such as whether SBHC staff could perform nursing program duties (thus easing registered nurse staffing requirements in the schools where health centers are established). The evaluation should fully explore sustainable financial models and, in particular, Medicaid reimbursement. The MFHA has drafted a RFP to identify a vendor to conduct an independent baseline assessment of the school nurse program and over the next fiscal year will conduct a process and outcome evaluation as the school nurse program implements new and evidenced-based strategies in the delivery of school-based services.

DOH proposed that it assume the lead responsibility for coordinating the financing and delivery and ensuring the quality of school health care services for the general student population in consultation with DC Public Schools (DCPS), DMH, CFSA, and other involved agencies.

The report recommended that although the mandates and authorities of each public agency differ somewhat, these interested parties must come together at the highest levels to develop a unified agenda to implement a school health plan and to develop unified policies with regard to:

- Responsibilities and commitments of each party
- Program models
- Mandatory and optional services
- Risk management
- Resource and expense sharing (including coordination of federal, local and philanthropic funding)
- Degree of flexibility for providers and principals to meet individual school needs
- Data management tools and evaluation process

Common decisions on these and other topics could be codified in a master memorandum of

understanding.

The school health plan delineated by MFHA proposed to concentrate first on improving essential structural and procedural aspects of a quality nursing program that are pre-requisites for establishing a student outcome measurement and evaluation system. These components include, for example, a) expanding the capacity to provide school health nursing services to all students in District public schools, b) ensuring that providers are well trained and qualified; c) generating the capacity to reliably collect valid data throughout the nursing program to drive the outcome indicator development process.

The DOH published a draft school health plan in January 2006, which proposed a timeframe and resource needs to deal with priority gaps and concerns. Comments from the public were solicited. The DOH key focus areas for FY 2007 include:

- Procurement and installation of wiring for Internet access for all DCPS health suites.
- Procurement of medical supplies and equipment for all DCPS and Charter schools with nursing services.
- Implement one to two pilot key initiatives focusing on STD education, counseling, testing, and treatment; and asthma or injury prevention.
- Equipping all health suites with computers and printers.
- Increasing by 30% the provision of full-time nursing coverage in schools
- Development of an electronic school health record and database.

The FY 2007 budget proposes an additional $9.75 million of appropriated District funds dedicated to these key focus areas, as well as to the development of standards of care and regulations for the school health nursing program in addition to adopting best practice models in the provision of nursing care. The DOH will also launch a process outcome evaluation of the program.

In April 2006, the Board of Education approved a "comprehensive system-wide health and HIV/AIDS education program" that includes standards, testing and treatment policies for DCPS. A partial list of features affecting the school health program includes:

1. Creating a cabinet-level school health administrator who will oversee all DCPS health-related and health promotion activities and ensure coordination of HIV/AIDS services with the schools;

2. Convening an advisory committee that will include participation from a diverse group of stakeholders, including but not limited to, the DOH, Children's National Medical Center, other local hospitals, the Mayor's Office, the Council of the District of Columbia, representatives from community based organizations, the School-Based Health Coalition, school nurses, parents, religious leaders and students.

3. Reaching out to medical homes, whose mission is to strengthen and integrate the primary care safety net clinics for the uninsured and underinsured residents of the District for inclusion in the DCPS Strategic Health Plan;

4. Revising DCMR Title 5, Chapters 23 and 24 to comply and meet accepted DC and National Health Education Standards;

5. Approving comprehensive, pre-K through 12 evidence-based health education and evaluation standards;

6. Providing DCPS students with access to HIV/AIDS programs taught by trained professionals

7. Ensuring that DCPS HIV/AIDS education efforts follow the epidemiology of the epidemic; focusing the most resources on reaching those at highest risk for HIV infection;

8. Providing professional development and training for all person working toward meeting health

education standards;

9. Adopting standards and training, approved by the DOH and based on CDC guidelines, for partner community based organizations providing HIV/AIDS prevention programs in the schools;

12. Improving communications with the public about DCPS HIV/AIDS and students' sexual health programming including standards, curricula content, and related public policies, by creating a web-based venue for communicating vital information about their HIV/AIDS and health-related programs. //2007//

/2008/ The District of Columbia estimated population is currently 581,530 as compared to the 582,049 figure for the 2005 Bureau of the Census. Approximately 57% of the district's population is African American, 31% are White, 9% are Hispanic, and 3% are Asians, Native Hawaiian, and other Pacific Islanders.

The District's 63 square miles are divided into eight wards on which local political representation is based and services are administered. While the median household income is $46,211, economic indicators vary widely across wards. Ward 3 in Northwest Washington, DC is the wealthiest with a median income of $71,975. Ward 8 in Southeast is the poorest ward with a $25,017 median income. Wards 6, 7, and 8 have the highest poverty rates in the District - 21, 25, and 36 percent respectively -- and the highest rates of children in poverty - 36, 37, and 47 percent respectively. These wards are overwhelmingly African American in population composition. Almost 20 percent of the population in the District lives below the poverty level.

In 2006, 9,369 individuals were homeless in the District, a 13.5 percent increase from 2004. There were 1,891 people identified as chronically homeless, meaning they had a disabling condition and had been either continuously homeless for a year or more or had at least four episodes of homelessness in the past three years. According to the District 's organization Continuum of Care, about 15 percent of the homeless were severely mentally ill, about 18 percent had chronic substance abuse problems, and about 6 percent were victims of domestic violence.

The TANF population in the District has changed over the past ten years. Since DC implemented welfare reform policies in 1997, its TANF caseload has fallen by 38%. As TANF caseloads fall, the characteristics and service needs of welfare recipients have evolved as families near the five-year time limit for benefits. As of April of 2007, the average monthly TANF caseload in the District was 15,500 families and the estimated annual program cost was $65,100,000.

Today, more than half of DC TANF recipients are either working or have worked recently. Working TANF recipients have jobs that pay about $8.50 per hour on average, well above DC's minimum wage. About half of employed recipients have paid sick leave and health insurance from their employer. Overall, most recipients (86 percent) remain poor, and about one third are extremely poor, with incomes of less than 50 percent of the poverty line, low skills, and facing personal, family, and logistical challenges that make it hard for them to work.

The District of Columbia has a newly elected Mayor and City Council Chairman as well as newly elected Council members and Council Committee chairs. Mayor Adrian Fenty outlined a 2007 Action Plan for the District. His vision for a Healthy City would assure access to affordable, comprehensive, high quality health care through established medical homes; access to affordable health insurance (cost-effective preventive care and health maintenance); a strong health care safety net (including coverage for medical needs, mental illness, pharmacy services, substance abuse, and oral health needs regardless of ability to pay); and tools to enable residents to maintain healthy and balanced lives. During Mayor Fenty's first 100 days and beyond, he highlighted 25 action items in the area of health.

In light of the high incidence rates of a variety of cancers and chronic conditions, the city

government allocated during FY 2007 $20 million of the tobacco settlement fund to the DC Cancer Consortium in order to implement over a three to five year period the previously developed 2005-2010 DC Cancer Control plan. An additional $10 million was granted to the American Lung Association of DC to enhance tobacco cessation and control across the city. MPCA has the responsibility of overseeing these two significant grants.

The FY 2007 Budget for the DC DOH exceeds $1.8 billion and includes 1,182 FTEs; 67% of the budget is from federal funding sources. The US Congress continues to have oversight and approval authority for the District's budget.

Shortly after the new city administration took office, the DC DOH instituted in January 2007 a realignment which consolidated the operational units within the Department into the following Administrations: Maternal and Primary Care Administration; Center for Policy Planning, and Epidemiology; Addiction Prevention and Recovery Administration, Medical Assistance and Health Care Safety Net Administration; Health Care Licensing and Regulation Administration; Emergency Medical Services Administration; HIV/AIDS Administration. However, these functional realignments could not be reflected in the FY 2007 budget and will be incorporated for the FY 2009 budget cycle. //2008//

/2009/ The District of Columbia estimated population in 2007 of 588,292 showed a 2.8% increase. In 2006, the population distribution was 55.5% African American, 34.5% Caucasian, 8.2% Hispanic, 5.1% including Native Americans, Alaskans, Hawaiians, and Pacific Islanders), 3.4% Asian, and 1.5% mixed (two or more races). Although the African American population is declining due to many middle class and professional African Americans leaving the city for suburbs, the District's white population has steadily increased, in part due to effects of gentrification in many of Washington's traditionally Black neighborhoods. The 2006 American Community Survey found that only 40% of current D.C. residents were born in the District, 16% below the national average.

District residents live in one of the eight Wards. Economic disparities are evident among the wards. For example, Wards 6, 7, and 8 comprise the majority of African American residents (79.2%) and more than 30% live below the Federal Poverty Level (FPL). Wards 4 and 1 comprise a significant proportion of the Latino population (20.8%) with expansion into Wards 5 and 6, due to rapid economic development.

The Rand Study (January 2008) reported that health outcomes in adult District residents varied significantly across wards. 1) Ward 7 had the highest rates of hypertension, diabetes, any chronic condition, and poor or fair self-reported health. These rates were statistically higher than the mean rate for all of DC. 2) Rates of hypertension, diabetes, and overweight/obesity were also higher in Ward 8 compared to the city-wide average. 3) Ward 5 had higher rates of hypertension and overweight/obesity compared to the citywide average. 4) The highest rate of obesity was in Ward 8. Rates of obesity were higher in Wards 4, 5, 7, and 8 compared to the city as a whole. Nearly three out of every four adult Ward 8 residents reported a height and weight that classifies them as overweight. Among key findings related to nutrition, physical activity and obesity for children in the District overall are the following: 1) Seven percent of children were reported to have a health issue that limits their ability to perform the activities of most children. 2) Across the city, 36 percent of children between ages 6 and 12 were overweight, while 17 percent of children between ages 13 and 17 were overweight. The Rand Study reported that 4.1% of District parents report that their children have poor or fair health and 12.1% believe that their children require more medical care than other children.

The Rand Study also cited several reasons for gaps in knowledge relative to children's health and access to care. Data is limited to National Survey of Children's Health. The most current is 2003. The Behavioral Risk Factor Surveillance System (BRFSS) asks if an individual has insurance but does not ask the type of insurance and therefore limits specific data. Other gaps include: limited mental data, emergency care, differences in data formats and availability if Medicaid and Alliance

data from managed care organizations and the lack of timely data analysis. As a result of the Study, the DOH has aggressively addressed the data collection needs and is currently collaborating with the Office of the Chief Technology Office (OCTO) to implement enterprise wide architecture that includes a master patient index and interfaces with each unique system application. The program is further described in Section B. Agency Capacity.

About one-third of Washington residents are functionally illiterate (DC LEARNS August 2007 issue), compared to a national rate (one in five). This is attributed in part to Hispanic, Ethiopian, and Eritrean immigrants that make up 12.7 percent of the District's population but are not proficient in English. It is also important to note that 45 percent of D.C. residents have at least a four-year college degree, the fourth-highest rate in the nation, illustrating the social divide present in the city. A 2000 study showed that 83.42% of Washington, D.C. residents age 5 and older speak only English at home and 9.18% speak Spanish. French is the third-most-spoken language at 1.67%.

The health and well being of women and children in shelters, transitional homes and on the street continue to be a major concern of the DOH. The Community Partnership for the Prevention of Homelessness (CPPH) reports on behalf of the District of Columbia the Annual Homeless Assessment Report (AHAR) for the Department of Housing and Urban Development (HUD). The purpose of the data reporting is to identify gaps in services, understand the nature of homelessness and analyze Continuum of Care effectiveness and utilizations. In January 2008 CPPH reported the age distribution of the 11,562 individuals in shelters for the period from October 2006 - September 2007 was: Ages 13-17 (.03%); 18-30 (8.0%); 31-50 (39.6%), 51-60 (18.8%) and 62 and older (3.8%). The District of Columbia Homeless Services Reform Act (2005) redefined Hypothermia and Emergency Shelter as Severe Weather and Low Barrier Shelter to ensure that the District's homeless population had access to shelter in the event of severe weather, such as extreme hot and cold temperatures, flooding and high winds.

The breakdown of single persons in the shelter system was 17 percent were women and 83 percent were men with a median length of stay at emergency shelters of 20 days. Twelve percent (12 %) of homeless women and eight percent (8 %) of homeless men stayed in shelter the entire year. One in ten persons in emergency shelter reported disabilities.

There were 1,618 single persons who used publicly funded transitional housing programs from October 2006 through September 2007. Twenty five percent (25 %) of persons served in transitional housing were also served in emergency shelter in FY07. Also, 91 percent of transitional housing beds were occupied on average throughout the year. And had a median length of stay in transitional housing was 172 days. Nearly one in ten clients in transitional housing were military veterans and over half of all transitional housing clients were disabled.

The number of families in the Emergency Shelter System was 1,661 persons in 507 families were served in publicly funded emergency shelters in FY07; 1,008 of the persons served were children, accounting for 61 percent of the population and 77 percent of adult persons in families were female. The median length of stay for adults in family emergency shelter was 160 days; 20 percent of families served in FY07 were in shelter for the entire year and 40 percent of the adults in families served were living with family or friends before entering shelter. Families in Transitional Housing accounted for 769 persons in 256 families were served in publicly funded transitional housing for families in FY07; 480 of the persons served were children, or 62 percent; 89 percent of the adult persons in families were female. The median length of stay for adults in family transitional housing was 361 days; 53 percent of families served in FY07 were in shelter for the entire year. On an average night during the period, 75 percent of family transitional housing beds were occupied.

DC's Mayor Fenty has a ten year plan to end homelessness. DC Village was closed in October

2007, which drastically changed the landscape of homeless services for families. Long-staying families already were placed in scattered site units of transitional housing through the District of Columbia's System Transformation Initiative. The changes to the District's continuum of care caused by the System Transformation Initiative are expected to be reported in the 2008 Report.

DOH has no direct services or medical care for the homeless or youth in DC. Unity Healthcare provides the medical services, and DHS contracts out for outreach services. $125,00 to be given to oral health will affect this.

The DC Alliance continues to increase enrollment of residents ineligible for other private or public assistance with an estimated enrollment to reach 50,000 in late 2008. Although health coverage is significantly higher in the District than other states, District health disparities as described in the Rand Study, continues to rank among the highest in the United States.

The District working in collaboration with commuity providers, Federal and agency providers is actively addressing the disparaties through a variety of efforts, including Cancer Coalition, Project WISH, Medical Homes; Hospital Discharge Program for Newborns; Child Health Action Plan and Interagency Collaborative Services Integration Commission (ICSIC). //2009//

//2010/ Since submission of the Title V Maternal and Child 2009 application the District has experienced a slight increase (3%) in its population. As with every state, the District is struggling with the effects of the recession from housing issues to employment needs to the need for health care services and food. Local funding is down 13%, with a 13.5% reduction for the DOH, primarily in the HIV/AIDS Administration and Addiction, Prevention and Recovery Administration. Although the decrease in local funding is somewhat offset by an increase in Federal Medicaid funding from the economic stimulus, DOH annual budget is affected.

DC HIV/AIDS Epidemic
DC health officials reported that at least 3% of District residents have HIV or AIDS, a total that far surpasses the 1 % threshold that constitutes a "generalized and severe" epidemic. That translates into 2,984 residents per every 100,000 over the age of 12 -- or 15,120 -- according to the 2008 epidemiology report by the District's HIV/AIDS office. Shannon L. Hader, Director of the District's HIV/AIDS Administration, reported that DC's rates are higher than West Africa; on par with Uganda and some parts of Kenya. She reports that the modes of transmissions include men having sex with men, heterosexual and injected drug use. Among the report's findings: Almost half of those who had connections to the parts of the city with the highest AIDS prevalence and poverty rates said they had overlapping sexual partners within the past 12 months, three in five said they were aware of their own HIV status, and three in 10 said they had used a condom the last time they had sex.

The District's report found a 22 percent increase in HIV and AIDS cases from the 12,428 reported at the end of 2006, touching every race and sex across population and neighborhoods, with an epidemic level in all but one of the eight wards. Black men, with an infection rate of nearly 7 percent, carry the weight of the disease, according to the report, which also underscores that the District's HIV and AIDS population is aging. Almost 1 in 10 residents between the ages of 40 and 49 has the virus. The report notes that "this growing population will have significant implications on the District's health care system" as residents face chronic medical problems associated with aging and fighting a disease that compromises the immune system.

It is expected that the HIV or AIDS rate is higher than reported because the city's numbers are "just based on people who've gotten tested." The study is the most precise count to date, according to the authors. The document is an update of a breakthrough 2007 report, which brought into clearer focus a picture of a city in the grip of a complex and "modern epidemic" that had traveled from a mostly gay population to the general one and disproportionately hit blacks. The current study notes that its tracking occurred as the city made a switch from a code-based

counting system to a name-based one. The surveillance unit interviewed medical providers to find unreported cases, pressed providers who did not consistently report to the administration and searched databases for unreported cases. More than 4 percent of blacks in the city are known to have HIV, along with almost 2 percent of Latinos and 1.4 percent of whites. More than three-quarters -- 76 percent -- of the HIV infected are black, 70 percent are men and 70 percent are age 40 and older.

DOH continues its collaboration with HAA to conduct outreach to and testing programs for the District's teens, as well as conducting classes within the DCPS on sexual health issues.

Immunization Award and Changes
The DOH secured $346,711 in additional funding for 2009 vaccination programs in the District. The funding was made available through the American Recovery and Reinvestment Act of 2009, also known as the stimulus package. The money will be used to purchase and make available vaccines for low income residents.

While adult immunizations have lagged behind the rest of the country, the District made great progress to improve the rate of immunizations among children. In May 2009, the District received the Highest Immunization Coverage Award for an Urban Area for 19-35 month olds from the Centers for Disease Control. The District's immunization rate for 19-35 month olds is 85.4 percent compared to 77.2 percent nationally.

The current immunization rates for DCPS and Charter Schools is 98%. DOH announced significant changes in the immunization requirements for children for the 2009-2010 school year that will affect school age children and those in a child development center. Changes include age defined requirements for pneumococcal, Hepatitis A, meningococcal, Tetanus, diphtheria and pertussis and HPV vaccines. Letters were sent to parents and guardians notifying them of the new requirements. DOH recognizes that the immunization requirements will be a compliance challenge. As of July 2009 compliance rates will drop to 52%. A copy of the immunization requirements is attached.

Department of Health Care Financing (DHCF) (formerly Medical Assistance Administration)
The DHCF was established as a separate DC agency. The agency continues its mission and objectives to serve the uninsured and under insured residents through management and oversight of the Medicaid and Alliance programs.

DC American Recovery and Reinvestment Act (ARRA)
The District developed 13 workgroups to plan, coordinate, and oversee activities related to ARRA funds under the general direction of the Executive Office of the Mayor and the Office of the City Administrator. These workgroups include: Broadband, Education, Employment, Energy, Health Care, Housing, Human Services, Medicaid, Natural Resources, Public Safety, Small Business, Tax, and Transportation. On April 7, 2009 DC conducted a community forum to provide guidance to business regarding health related funds. Community based organizations as well as agencies focused on decreasing and mitigating youth violence submitted proposals for funding under the ARRA. //2010/
An attachment is included in this section.

B. Agency Capacity

The District of Columbia has designated the Department of Health (DOH) Maternal and Family Health Administration (MFHA) as the Title V state agency, with responsibility resting with the state maternal and child health officer. Formerly the Office of Maternal and Child Health, the agency was elevated to administration status in February 2001 and, along with several changes made in the DOH organizational table over the past year, is undergoing another proposed realignment as this application is being prepared. The senior deputy director of Maternal and Family Health Administration (or designee) will function as the state maternal and child health officer. That

position is currently vacant, with a hire expected by October 1, 2005. Until that time, Marilyn Seabrooks Myrdal will continue to serve as the Title V officer.

/2007/ Carlos Cano, MD was appointed Senior Deputy Director of the Maternal and Family Health Administration in October 2005. Dr. Cano was trained as a psychiatrist and family therapist. As a health policy analyst and medical advisor with the Centers for Medicare and Medicaid Services, he supported drug and medical device policy development. During that time he also became familiar with an array of medical, public health, and social interventions centered on infants, young children, and mothers which have produced significant and measurable improvements in life expectancy and other health measures in both advanced and developing countries.

Also effective October 2005, was a realignment of MFHA in which seven former divisions were reorganized into five primarily population-based bureaus. In announcing these changes in fall 2005, the DOH director wrote:
"The overarching goal for the administration in the next few years will be to reduce the rates of untimely deaths and preventable disease among babies, children, and mothers in our city.... due to ethnicity, socioeconomic class, and geographic location ... to reduce infant mortality to no more than 8 per thousand live births per year by 2010."

In implementing the changes in organizational structure described above, Dr. Cano convened meetings with staff and management to resolve personnel reassignments and other issues pertaining to the changes. He has established regular meetings with mid-level staff. One issue, still under consideration, pertains to the former data collection and analysis division. The DOH is considering centralizing the various surveillance, management information systems and data analysis functions now located throughout the department. Pending a final decision, the staff of the MFHA data collection and analysis division has been subsumed in the Adult and Family Health Services Bureau, which is also responsible for services to the other bureaus--transportation, telephone information and referrals, advisory committee affairs, internal and external communications, and health promotion activities. //2007//

Several laws affect the responsibilities and authority of the Administration:
- Title III of the Child and Youth, Safety and Health Omnibus Amendment Act of 2003, DC Law B-15-607 directed the development and implementation of a universal health screening form, the child health certificate and oral health assessment form implemented in 2005.
- DC Law 6-13 Newborn Screening Requirement Act of 1978, Amendments Act of 1985
- DC Law 3-33 Newborn Health Insurance Act of 1979, which mandates 3rd party payment of newborn metabolic and genetic screening
- DC Law 13-276 Universal Newborn Hearing Screening
- DC Law 7-45, Sec 31-2421, Public School Nurse Assignment Act of 1987, which requires a minimum of 20 hours of nurse coverage per school
- DC Law 10-55 The Administration of Medication by Public School Employees Act of 1993
- DC Law 3-20 The Immunization of School Students act of 1979
- DC Law 6-66 The Student Health Care Act of 1985, which requires pre-k, 1st, 3rd 5th, 7th, 9th, and 11th grade students have a comprehensive physical and dental examination and directs the school health division to review the records and notify schools of students who are out of compliance

MFHA's position authority for FY 2005 is 142 full-time positions, 50 of which are supported by federal Healthy Start funding and 57 by Title V monies. 35 are supported by other grants; none are funded by state-appropriated monies. Currently, only 9 positions are vacant, a lower rate than in past years. Since 2000, the position authority has varied from 140 to 158 FTEs. Many of the staff and managers are seasoned District employees. The staff consists of 17 registered nurses (several master's-prepared), 1 LPN, 2 masters of social work, 1 DDS, 1 RD, 1 MD, and 1 CHES. 5 hold MPH degrees. The majority of employees are of African American heritage, reflecting the composition of the District population. There is 1 bilingual (Spanish-English) nurse.

/2007/ MFHA operated in FY 2006 with an approved budget of $36.6 million, approximately 73% of which comes from federal grants, and has position authority for approximately 192 FTEs. The increase over the previous year represents the transfer of WIC and other nutrition programs and the children's lead poisoning prevention program to MFHA. Of the total 192 FTEs, 73 are supported by the block grant. There are currently five vacancies. Disciplines represented on the staff are: nursing (15); physician (1); dentist (1); social work (2). Six staff members have completed the MPH.

The following are the major Title V (TV) organizational components of MFHA.

Adult and Family Health Bureau 20 TV FTEs
Child, Adolescent and School Health Bureau 10 TV FTEs
Children with Special Health Care Needs Bureau 17 TV FTEs
Nutrition and Physical Fitness Bureau 1 TV FTEs
Perinatal and Infant Health Bureau 6 TV FTEs
Office of the Senior Deputy Director 13 TV FTEs
MFHA staff have applied for several new grants this spring and summer; to date no additional awards have been received. //2007//

The DOH continues to experience difficulties in retaining staff and hiring qualified candidates. Although the length of time required to advertise, recruit and fill positions has diminished, there is still a substantial period between the time when a qualified candidate is identified and when an official offer of employment is made. In 2005, personnel functions and hiring decisions in the department were centralized at the director's level (previously at the administration level.)

MFHA received 2 new grants in FY 2005-- Accessing Health Care for Children and Youth with Epilepsy residing in Medically Underserved Areas in the District of Columbia, and Screening and Treatment for Perinatal Depression. A notice of award for a lead poisoning prevention grant has been received for FY 2006. The purpose of the grant is to conduct assessments and remediation of lead and water pipes, followed by comprehensive risk assessments of children in homes with lead exposure. The 2 federal Healthy Start grants were refunded following a competitive application process. The Healthy Start project in Wards 7 and 8 was awarded a 4-year grant of $2,350,000 annually (CFDA 93.926E, Eliminating Disparities in Perinatal Health), beginning July 1, 2005. The Healthy Start project in Wards 5 and 6 was awarded a 4-year grant of $1,350,000 annually, also beginning July 1, 2005. In anticipation of level funding, several services were adjusted, resulting in a change in staffing. 6 Healthy Start paraprofessional outreach positions and 1 driver will be transferred to the Nutrition and Physical Activity Bureau where the incumbents will be assigned similar outreach duties, allowing their knowledge of their communities to be retained in the Administration.

Several grants are ending this fiscal year--The MCHB-funded newborn hearing screening, and the CDC-supported birth defects registry. As this application is being prepared (July 8, 2005), MFHA officials are uncertain as to the possibility of refunding for the hearing screening grant. In the absence of federal funding, MFHA officials will consider the possibility of allocating block grant monies to fill the audiologist position and continuing the technical assistance provided to MCOs, hospitals and early childhood development programs.

An evaluation of the discharge program, which involves surveying mothers utilizing services from the program, is currently underway. The future of the birth defects registry is uncertain. Data collection is linked to maintaining the newborn hospital discharge program

/2007/ A new hearing screening grant was received for FY 2006. The audiologist position was not filled. The birth defects registry has been discontinued due to lack of funds. The hospital discharge planning program was discontinued as well, effective June 2006. A pilot "bridge" project targeted toward the population most at risk for potential social and medical complications will replace it and is being implemented as of this writing. //2007//

MFHA staff is housed in several locations: the central office of the DOH; Addiction Prevention and Recovery Administration office sites; the campus of St. Elizabeth's Hospital; the campus of DC General; sites throughout the city including clinics, WIC centers and labs.

/2007/ Healthy Start staff was relocated to offices of the former DC General Hospital in October 2006. Staff reports problems with Internet access and long distance fax capabilities. CSHCN Bureau staff was relocated to offices in the central DOH building where other MFHA bureaus are located with the exception of the Adult and Family Health Services Bureau, which is slated to move to the central DOH building this summer. //2007//

MFHA leases several vans for transport of clients and staff. From 1994 to June 2003, Healthy Start operated the Maternity Obstetric Mobile (MOM) unit, a 40 feet unit with 2 fully equipped examination rooms, audio-visual equipment, and health education materials. The unit serves the project area, providing a range of curbside services (depending upon available staff)--pregnancy tests, health screening, health education, immunizations and enrollment in case management. The unit was retired in June 2003, and a replacement ordered. The new unit will have a dental chair and a dental hygienist will provide oral health screening to pregnant and postpartum women. It is expected to be available for operation by the beginning of FY 2006.

/2007/ The projected time for operation of the mobile unit is now October 2006. //2007//

MFHA maintains a Maternal and Child Health Resource Center at the central DOH office. A variety of print and video materials are available to DOH staff and staff of community based providers. The Healthy Start project maintains a library of training materials at its site.

In FY 2003 MFHA employees petitioned to and eventually voted to form a bargaining unit. Approximately 145 of the then-158 Administration positions became subject to union scale wages, resulting in a nearly 8% increase in labor costs for FY 2004.

In the summer of 2003, MFHA engaged a consultant recommended by MCHB to work with management to complete athe CAST 5 analysis. Following the preliminary work, senior staff and other managers completed a 2-day training and retreat on September 10-11, 2003. The 2nd phase of the analysis took place June 29-30, 2005. The results have been used to define MFHA's technical assistance needs for this application. The report will be circulated to the senior deputy director for Maternal and Child Health Administration when the position has been filled. An orientation and strategic planning retreat for the Administration will be convened at that time.

MFHA participates in AMCHP, CityMatCH and APHA, sending staff to conferences and skills training sponsored by these professional organizations and making presentations on special projects.

Special Needs Capacity

Joyce Brooks, MSW, continued to direct the CSHCN division, which consists of 25 FTEs, funded by two federal grants in addition to Title V--newborn hearing screening and access to care for children with epilepsy. The childhood lead poisoning prevention program, which receives funding from the Department of Housing and Urban Development and the Centers for Disease Control and Prevention, is being moved from the DOH Environmental Health Administration to the Maternal and Family Health Administration, Child Health Services Bureau, which will replace the CSHCN division. Currently, 5 of the 25 positions are vacant. In addition, there is no audiologist on staff, a previously grant funded position that is key to the operation of the newborn hearing screening program. There is 1 RN and 1 LPN on the staff.

CSHCN division staff members are active in an array of inter- and intra-agency and public-private partnerships that focus on a broadly defined special needs population, including the DC Intra-

agency Coordinating Council (Part C) and Developmental Disabilities State Planning Council, and coordination with the DC Early Intervention Program (DCEIP).

The division coordinates with a range of government agencies and private sector organizations, a few of which are described in this section of the application. Since June 2002, the Administration has had a MOU with the Office of Early Childhood Development (OECD), which includes the Early Intervention Program (DCEIP) in its scope of cooperative activities. The CSHCN division is responsible for coordination with OECD. The MOU covers database linkage and tracking of clients across various services and programs administered by the 2 agencies; training of Healthy Start and information and referral staff in Part C program guidelines and services; and jointly offering training for Head Start and pre-kindergarten program staff, mental health providers, child care providers and early intervention programs. The Administration, OECD and various other stakeholders developed a universal health form now being used by schools and all other District early care and education programs. A protocol for reciprocal referrals and for the provision of client specific information was developed to increase the participation of eligible children in Part C and other programs for children with special health care needs.

OECD offers periodic training to its subsidized child care providers to help them to meet licensure requirements. These training sessions are now incorporating the dissemination of information from the Administration. The MOU must be renewed periodically.

Coordinative activities with the OECD have been supported by a 3-year Early Childhood Comprehensive Systems grant from MCHB, now concluding its 2nd year. Focusing on development from the prenatal period through age 8, the grant is being used for environmental scanning and resource mapping, with the expected end result being a realistic plan for services integration. The CSHCN division participates with other city initiatives focusing on early childhood, such as the Early Learning Opportunities Act Grant (ELOA), addressing ages 3 and 4, the Kellogg Foundation SPARK grant for "Supporting Partnerships to Assure Ready Kids," addressing ages 3 to 5, and the DC Education Compact which is developing a Strategic Plan for DC Public Schools, to overlap age cohorts and build a system based on a developmental definition of childhood (0-8).

/2007/ The Early Childhood Comprehensive Systems grant was extended for another year to allow for completion of planned contractual services. Administration of the grant was transferred from the CSHCN Bureau to the Child, Adolescent and School Health Bureau.

The CSHCN division became a bureau effective October 2006. The bureau has been headed by interim chief Joyce Brooks. In June 2006 the position of chief was advertised with a closing date of July 10, 2006. //2007//

/2008/ The components of MPCA formerly constituting the Maternal and Family Health Administration operate in FY 2007 with an approved budget of $38.9 million; approximately 73% of the budget is comprised of federal grants. MFHA counts 185.5 FTEs, of which 70.34 FTEs are funded by the Title V Block Grant. The following are the major organizational components of MFHA:

Adult and Family Health Bureau 20 TV FTEs
Child, Adolescent and School Health Bureau 10 TV FTEs
Children with Special Health Care Needs Bureau 17 TV FTEs
Nutrition and Physical Fitness Bureau 5 TV FTEs
Perinatal and Infant Health Bureau 6 TV FTEs
Office of the Senior Deputy Director 12.34 TV FTEs

Special Needs Capacity
In August 2006, Joyce Brooks, MSW, was selected as the Children with Special Health Care Needs (CSHCN) Bureau Chief. In 2006, the Childhood Lead Poisoning, Screening, and

Education Program (CLPSEP) was transferred to MFHA and incorporated into the CSHCN Bureau. However, in the context of DC DOH's realignment and creation of MPCA and given the importance of abating lead poisoning in the city, CLPSEP has constituted the basis of a new Lead and Environmental Hazards Bureau.

The CSHCN Bureau is focused on strengthening established partnerships as well as establishing new partnerships and relationships with various stakeholders. The Bureau is working to strengthen and improve collaborative relationships with Medicaid to enhance the identification of children with special health care needs under the Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) program.

In order to address the issues of pediatric mental health, the CSHCN Bureau has joined the Early Care and Education Administration Advisory group on Mental Health. Both Joyce Brooks, Bureau Chief, CSHCN, and Michelle Sermon, Newborn Screening Coordinator, serve on the Early Childhood Mental Health Committee that has been established to develop a comprehensive service delivery system for all children 0-5 in the District of Columbia. Ms. Brooks serves on the Funding Subcommittee responsible for gathering all of the major child serving agencies in the District of Columbia to help coordinate mental health related practices to use evidence-based strategies. Ms. Sermon serves on the Public Information Subcommittee ensuring that all families are made aware of the new system being developed.

The CSHCN Bureau is also an active participant with the Universal School Readiness Stakeholders group working to focus on and target children with special health care needs. This past year, the Bureau conducted a presentation to the students and participants of the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. As a result, the Bureau has been invited to identify prospective applicants for the LEND program.

The CSHCN Bureau has continued its partnerships with the Howard University School of Social Work and Genetics Program. Two students from each program have interned with the Bureau working within the Newborn Metabolic and Hearing Screening Programs, the Woodson Wellness Center, and in other bureau initiatives Lead Screening Preventio Program and Child, Adolescent, and School Health programs.

While the various chronic disease programs within MPCA are currently primarily teen- and adult-focused, the CSHCN Bureau will seek to establish effective relationships and collaborations with these programs and the Birth-to-six program in an effort to raise the consciousness and awareness of children with chronic conditions.

The CSHCN Bureau was also invited to participate in the DC Partnerships to Improve Children's Healthcare Quality (PICHQ) Advisory Board. The Bureau will become a more active participant on the PICHQ Advisory Board.

The Senior Deputy Director for the Maternal and Primary Care Administration has an interest in exploring and perhaps replicating the Rhode Island Medical Home Project in the District. Rhode Island's Pediatric Practice Enhancement Project (PPEP) provides parent support personnel to primary care physician who serve a large percentage of CSHCN and their families. Parent consultants are placed in targeted primary pediatric offices and assist the physician in providing a comprehensive coordinated medical home to about 300 families annually. Parent consultants link families with necessary community resources, assist physicians and families in accessing specialty services, and identify and resolve with the PPEP Steering Committee systems barriers to coordinated care. The PPEP is a partnership between the Rhode Island Department of Health, Department of Human Service, and the Rhode Island Chapter of the American Academy of Pediatrics. The CSHCN Bureau and Dr. Cano plan to visit Rhode Island to better understand the project evaluate its appropriatness as a model in DC.

The MPCA has identified funds during the current fiscal year to provide direct services to the

community. The CSHCN Bureau will award sub-grants to several community based organizations to provide services for children with special health care needs. The funding of these services is in keeping with the US Department of Health and Human Services, Maternal and Child Health Bureau's mission that calls for states to have service systems for children with special health care needs which encompass the implementation of a comprehensive, culturally sensitive, accessible, coordinated community based health partnership with numerous organizations and individuals and develop a model of family-centered care for children with special health care needs.

These services will also assist the Bureau in meeting the six core outcomes for children with special health care needs as part of the national action plan to achieve community-based service systems for CSHCN and their families. Sub-recipients are expected:

To provide scholarships for 31 campers and transitional youth to attend camps that serve children with Neurofibromatosis (NF-1), Tourette Syndrome, Epilepsy, and Teen leaders with chronic health conditions and disabilities during the summer of 2007.

To provide technical assistance in conducting six summer workshops for parents of transitional youth to increase their knowledge of vocational rehabilitation, exploration of career options, disability awareness, and other topics related to transitional services for youth with special health care needs.

To enhance follow-up services for children identified with sickle cell disease, sickle cell trait and related disorders. These services include genetic counseling, care coordination and pediatric services.

To provide sickle cell disease education to school-aged children in DC Public Schools, recreation centers, and public events for the purpose of increasing knowledge of sickle cell disease and conveying the importance of knowing your sickle cell status.

To subsidize childcare services for families of children with special health care needs.

To establish a fund for insured families that have reached the maximum of their benefits to provide medications, medical supplies and equipment for children with special health care needs.

To provide early identification of children with developmental disabilities through timely and comprehensive assessments.

District Title V Capacity

The District's Title V program has the capacity to provide preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; services for CSHCN; and culturally competent care that is appropriate for the District's MCH population.

August 2006 marked the 15th year of operation for the District of Columbia Healthy Start I Project, which serves Wards 7 and 8. The project is coordinated with another federally funded Healthy Start Project II in Wards 5 and 6 that is funded under a separate application.

The Perinatal and Infant Health Bureau is currently looking at ways to expand home visitation and reach out to more women at social or medical risk for adverse perinatal outcomes. In the next few months, MPCA plans to start utilizing family support workers, who in conjunction with the nurse case manager will provide home visits to pregnant women. These duties will include providing support and guidance; reinforcing the importance of following up with medical appointments and referrals; and providing assistance with enrollment in Medicaid, WIC, and other entitlement programs. MPCA anticipates that the expansion will result in a net increase in capacity to serve an additional 80-100 pregnant woman in Wards 5, 6, 7, and 8.

In late September 2006, the new Healthy Start Maternity Outreach Mobile (MOM) unit was delivered. The unit replaces the MOM Unit that was originally launched in 1994. Following a three-year absence of mobile unit services, staff spent the first quarter of the program year involved in redeployment activities, including reevaluating old sites, identifying new sites, and building partnerships for the provision of services. The MOM unit serves in the adjacent Wards, 5, 6, 7, and 8.

The MOM unit services represent a major outreach strategy that focuses on the early identification and recruitment of pregnant women not yet enrolled in prenatal care. The new unit will target high-risk neighborhoods (for example, those with high infant mortality and HIV infection rates) and will include services that are equivalent to a first prenatal visit (including laboratory work-up) for pregnant women not yet enrolled in care and they will link women to traditional prenatal care and entitlement programs such as Medicaid, WIC and TANF. The MOM unit promises to be an effective strategy to assure that high-risk pregnant women receive early prenatal care. A nurse practitioner and an outreach technician provide services on the MOM unit. Women seen with a positive pregnancy test receive a physical examination and are screened for a variety of risk factors (e.g., substance abuse, depression, and domestic violence). A full panel of laboratory tests are completed and sent to the city laboratory. Pre-test and post-test counseling is encouraged. Recently, staff met with the Childhood Lead Prevention, Screening and Education program to introduce screening pregnant women for lead levels and to educate them on the need for infant screening.

In 2006, the hiring of a Public Health Advisor expanded the staff in the new Child, Adolescent and School Health Bureau to provide additional school health services. The Public Health Advisor coordinates policy development for the Child, Adolescent, and School Health (CASH) Bureau. Her current responsibilities include developing and revising school health legislation and regulations, and researching and recommending policy initiatives in the areas of child, adolescent, and school health.

In FY 2008, CASH will finalize the overhaul of the school health policies and regulations and plans to establish an Advisory Committee on School Health to assist with research and policy development in this area.

New Program Capacities

The MPCA received a State Data and Assessment Technical Assistance (DATA) Mini-grant from the Association of Maternal and Child Health Programs to provide training in program evaluation to our staff. The training focused on the development of a framework for effective program evaluation of MPCA's program activities. MPCA provided a sub-grant to the School of Public Health Services at George Washington University to conduct a series of program evaluation workshops for staff in MPCA.

MPCA received a new five-year grant to continue funding for the State Systems Development Initiative (SSDI) which is designed to collaborate and improve partnerships for linking data systems, improve research and planning capacity, conduct needs assessments, prepare data analyses, and more effectively utilize performance measures. The SSDI grant is designed to complement the Title V Maternal and Child Health (MCH) Block Grant Program. In the FY 2007-FY 2011 cycle, MPCA will develop a comprehensive strategy that leads to better and more timely data, and then use data to stimulate more effective program planning, improve our monitoring capability, and begin using evaluation tools to provide timely feedback to program planners and stakeholders.

Specific SSDI Grant projects include (1) linking newborn screening data with birth, infant death, Medicaid Recipient, WIC, and social services benefits (ACEDS) files; (2) making data sets available to DOH data groups, and academic researchers interested in working on MCH issues

and problems; (3) working with community stakeholders; (4) start a Phase II Perinatal Periods of Risk (PPOR) program to address infant mortality disparities; (5) building an interactive website to allow community groups and stakeholders to access MCH data; (6) working on other SSDI-related projects, including working on a two-year needs assessment process; and (7) assisting in developing an integrated MCH information system designed to tie together multiple activities within a single database, including the development of a school health information system.

MPCA received a new five-year grant from the Centers for Disease Control and Prevention to continue funding for the Rape Prevention and Education Program. This Program is designed to conduct surveillance of rape and sexual assault in the District and monitor trends; provide education to and increase sexual awareness among students in DC public and charter schools; provide sexual assault prevention and education to increase community awareness; develop a comprehensive violence prevention plan; and conduct ongoing evaluation of rape and sexual assault prevention activities. MPCA has sought technical assistance from the Children's Safety Network (CSN) in developing effective injury-related performance measures and evaluation strategies for injury and violence prevention programs. The Maternal and Child Health Bureau (MCHB) funds the CSN to support state MCH injury programs'

CSN will assist MPCA and state MCH agencies and their partners with public health data sets that MCH agencies can use to address injury- and violence-related performance measures. CSN will provide assistance to enhance MPCA's capacity to analyze data and surveillance needs to better understand and address preventable injury in DC. CSN will conduct a data analysis webinar during which MPCA will review the strengths and weaknesses of state and local injury data sources, including the 11 data sets in the consensus recommendations for injury surveillance in State health agencies. CSN will also provide guidance to MPCA in the development of a sexual assault prevention plan.

In 2002, President Clinton signed a law to create minimum standard for Cultural and Linguistic Competency in health services based on the CLAS standard published in the Federal Register in December 22, 2000. In 2004, Mayor Anthony Williams signed specific legislation to facilitate access to service to all LEP individuals residing in the District of Columbia called the Language Access Act.

Cultural competence is the ability and the will to respond to the unique needs of an individual patient/client that arise from the client's culture and the ability to use the person's culture as a resource or tool to assist with the intervention and help meet the person's needs. Achieving cultural competence is both a gradual process and a goal toward which professionals and organizations can strive to achieve. MCPA is developing mechanisms to increase cultural competence.

/2009/ The Community Health Administration (CHA) oversees the Bureaus responsible for the oversight, management, planning, and evaluation of the Maternal and Child Title V Block Grant. The Perinatal and Infant Health Bureau, Special Health Care Needs (SHCN) Bureau, and Child Adolescent School Health (CASH) Bureau along with the Oral Health Program, and Nutrition and Physical Fitness Bureau. The Lead Program, previously under the SHCN Bureau will be re-assigned to the District Department of Environment (DDOE) in Oct 2008.

The District's 2009 capacities are briefly described below:

The Special Health Care Needs Bureau continues to focus on strengthening partnerships with community organizations as evidenced by it's sub grant awards to the Goldberg Center for Community and Pediatric Health, Epilepsy Foundation, and Easter Seals. SHCN ‘s efforts are focused on addressing the six core performance measures of the state. The development of partnerships is our response to developing a community based system of care for families: 1) establish a DC Parent Information Network -- Planning and Implementation Phase; 2) increasing services for SHCN's families. Interventions considered in the future included transition

care/coordination; family navigation to included financial assistance to families with specialty care expenses not covered by insurance or Medicaid.

The Bureau is an active participant in several committees e.g. DC Hears Advisory Board; The Metabolic Advisory Board is empowered to make recommendations regarding newborn screening policies; and Early Comprehensive Childhood Services (ECCS) that focuses on the critical components of access to comprehensive health services and medical homes.

Perinatal and Infant Health Care Bureau provides oversight of the Healthy Start Program as well as Infant Mortality Action Plan. Under the leadership of Karen P. Watts, RNC, FACHE, FAHM, PMP, the Bureau has implemented a variety the activities. In December 2007 the District published the "Addressing Infant Mortality in DC: Citywide Action Plan" to respond to the maternal and child health needs in the District and reduce infant mortality rates throughout the city. It also convened the year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices and provide recommendations to CHA based on existing data regarding infant mortality and perinatal outcome disparities.

Child, Adolescent School Health (CASH) Bureau responsibilities include the management and oversight of the following programs: 1) Health and Sexuality Classes presented to students in grade Pre-Kindergarten to 12 in the DC Public and Charter schools as well as two private schools. The goal of the classes to older students include: reduce teen pregnancies, reduce Sexually Transmitted Diseases, and reduce high risk behaviors by encouraging good health life styles. It will expand the sexual health program utilizing the CARRERA model. CASH has oversight for the school nurse program. 183 schools (28,258 children) receive school nurse services. The school nurses collaborate with the DOH to ensure that the children meet the immunization compliance requirements of 96.5 % compliance. The current compliance rate is 97%.

The Oral Health Program provides oral health education to DCPS children as well as dental exams and sealants to third graders in several schools. It works with MAA to promote dental services and identify dental providers to provide services.

The Nutrition and Physical Fitness Bureau with collaborative efforts between District agencies and private partners developed initiatives that will shift eating behaviors from foods with limited nutritional value to those with higher nutritional dietary value. Also $600,000 in local funds for FY 2009 have been made available for grants to fund grants to address childhood obesity.

The Lead Program continues to identify children at risk of exposure to lead through mandatory blood level screening for those < the age of six by each provider or facility and reporting of the results to the District. The Lead Poisoning Prevention Program focuses on surveillance, screening and home assessment of children with levels at or = to 5ug/dL. The Lead Program will move to DDOE in October. It collaborates with DCRA, MAA, SHCN Bureau and Perinatal and Infant Health Bureau to expand screening and MCO case management services as well as mitigate sources of lead in the home.

The Disrict will develop a new Birth Certificate to be released January 2009 which will alleviate some of the District's data collection problems. It will include mothers age, sex, race, ethnicity, residence, education, prenatal care, alcohol and tobacco use before birth, low birth weight, and other important health indicators.

Technical Assisance has been requested to increase cultureal competence in DC.

The D.C. CSHCN Advisory Board was established in May 2001. The Board is composed of approximately 40 members including representatives from public/private organizations, parents of CSHCN, physicians, educators, advocates, citizens, and other interested individuals who are residents of the District of Columbia or represent agencies and organizations concerned with

services and resources for children with special needs and their families in the District of Columbia. Subcommittee members do not have to be residents of the District of Columbia. Currently the charge of the D.C. CSHCN Advisory Board is to advise the CHA on:

1. The health care needs of families and CSHCN;
2. Monitor program guidelines and criteria to provide effective, quality care programs for CSHCN and their families;
3. Use of federal and local funds for CSHCN, administered through the CHA; and
4. Development and implementation of a strategic agenda to ensure the delivery of comprehensive, continuous, coordinated, culturally competent, family-centered, community-based services for CYSHCN.

Technical assistance to enrich the advisory board was requested specifically to increae parent participation, increase cultural diversity on the board, include youth involvement. //2009//

/2010/ The Community Health Administration (CHA) oversees the Bureaus responsible for the oversight, management, planning, and evaluation of the Maternal and Child Title V Block Grant including the Perinatal and Infant Health Bureau (PIHB), Child Adolescent School Health (CASH) Bureau, and the Nutrition and Physical Fitness Bureau. The Lead Program was re-assigned to the District Department of the Environment (DDOE) in October 2008. CHA continues its efforts to expand parent participation and cultural diversity through inclusion in the CSHCN Advisory Board and in 2010 will recruit youth members.

As a result of retirement and reduction in staff, the special needs functions have been appropriately placed in 2 existing bureaus that already have excellent staff assuming similar responsibilities. The Child Adolescent School Health Bureau (CASH) and the Perinatal and Infant Health Bureau (PIHB) will provide high quality program support to children and youth with special needs. The PIHB and CASH Bureau continue their efforts to develop a community based system of care for families expecially with special needs

CASH
will oversee the development of a coordinated, integrated system of health care for children and youth with special health care needs (CYSHCN. Initially this will include a Medical Homes Pilot to utilize parent navigators to help other families navigate the healthcare system; implementing learning collaborative sessions to familiarize other providers with the medical homes concept and establishing a medical home-parent advisory council. Also planned is CYSHCN Symposium to introduce a CSHCN state plan and to develop action plan. CASH will also be monitoring TItle V funded Destination Known: Making Health Care Transition Happen for YSHCN in DC who are transitioning from pediatric care into adult care. This initiative will then identify best practice models for transition case management. CASH directs the DC Parent Information Network (DC PINS) and the Early Comprehensive Childhood Services (ECCS) focuses on the critical components of access to comprehensive health services and medical homes of al SHCN including autism.

CASH continues oversight of Health and Sexual Education Programs to selected DC Public Schools; school oral health and education programs. The DC Control Asthma Now (DC CAN) in 2009 published its "Burden of Asthma in DC"and "DC Strategic Plan 2009-2013". Burden of Asthma Report highlighting the prevalence of adult and childhood asthma in the District.

Title V and the Preventive Health block grant are pooling resources to support Youth Violence Prevention. The awardees will build capacity in DC communities to engage youth violence and crime prevention strategies to effect community change, improve access to services, and build coordinated networks of community stakeholders to address violence.

The goal is to address the complicated issues that promote gangs/crews and facilitate violence among young people in a particular service area in the city.

CASH continues its oversight for the school nurse program; with a major focus to ensure immunization compliance its goal of 96.5%. Currently children's immunization compliance for DCPS and Charter Schools is 98% CASH is exploring the requirements for home schooled, private and parochial school immunization requirements. CHA continues its relationship with the School Nurse Advisory Board receiving advice on legislation and initiatives that impact school health

PIHB
will facilitate the Universal Newborn Metabolic Screening to ensure that all children, including those with special needs are screened for 40 metabolic and genetic disorders hospital discharge. PIHB staff with then promptly follow up on positive screens. The Newborn Hearing Screening program will also be in PIHB. All children born in the DC are screened for hearing disorders. PIHB staff will contact families if there is any abnormal result and will ensure follow up by proper medical providers. PIHB will oversee the DC Greater Access to Pediatric Sickle Cell Services (DCGAPS) project where staff will contact those diagnosed with Sickle Cell trait or disease with correct referral to Howard University Hospital (HUH) Department of Pediatrics which coordinates care through a medical home. HUH also assists youth living with Sickle Cell on successful transition into adulthood.

PIHB will continue oversight of the Healthy Start Program and the Infant Mortality Action Plan. Its Advisory Board, extended for a second year, identifies and compiles best practices and provide recommendations to CHA based on existing data regarding infant mortality and perinatal outcome disparities. Its evaluation process includes incorporating systemic assessment of psycho-social and behavioral risk and protective factors part of perinatal, infant and prenatal intra conceptual practice. It continues the successful Family Support Worker outreach program. In 2008 there were 600 women visited by the program. It also developed and launched a comprehensive public information campaign "I am a Healthy DC Mom". The themes included are "I will stay fit and eat right", "I will commit to 40 weeks" and "I will keep my baby safe and healthy". The campaign will include a Public Information Component, a Bed Sharing campaign, and distribution of Pregnancy Assistance Kits. TItle V will fund teen pregnancy prevention programs aimed at preventing second pregnancies to impact the rates of subsequent pregnancies.

Nutrition and Physical Fitness Bureau with collaborative efforts between District agencies and private partners developed initiatives that shift eating behaviors from foods with limited nutritional value to those with higher nutritional dietary value. The Bureau works with the PIHB in identifying women who need breastfeeding counseling and who may need home lead testing.

The Lead Program activities include a weatherization and energy program; school nurse program to ensure completion of "lead test" questions on school forms; Lead Van in Asian communities; legislation changes including the definition of lead based paint hazards and rental property owner requirements to provide tenants lead free reports on properties.

As of 2010 the Bureau of Cancer and Chronic Disease (BCCD) will be responsibile for the Asthma Program. //2010//
An attachment is included in this section.

C. Organizational Structure

Following legislation in 1997 that established the DOH, a mayoral administrative issuance, followed by a departmental organization order, designated the Administration as the Title V state

agency for the District of Columbia. Marilyn Seabrooks Myrdal, MPA was appointed the state chief maternal and child health officer to direct the Administration (then the Office of Maternal and Child Health) May 2000. Until recently, the maternal and family health programs continued under the purview of the senior deputy director of health promotion, a position also responsible for the Office of Nutrition Programs. As this application is being prepared, the Administration is being realigned: DOH management is replacing the position of senior deputy director of health promotion with the senior deputy director of the Maternal and Family Health Administration, and bringing nutritional services into the Administration. The senior deputy director will report directly to the DOH director. Recruitment for the position is underway with a decision expected by October 1, 2005.

In this section of the application, the current organizational structure will first be described, followed by a description of the plans, as they are known to date (June 30, 2005) for the realignment.

For several years, maternal and family health programs and Title V functions were organized around 7 divisions. An administrative officer and staff-- responsible for procurement, personnel and budget issues, as well as training and staff development--who previously reported to the state chief maternal and child health officer were transferred to the chief of staff, office of the deputy director of health promotion in Fiscal Year 2005. (See organizational tables, appendix) The division officers and their dates of appointment are as follows:

Data Collection and Analysis	Deneen Long White	1/98-6/05
Family Services	Diane Davis, RN	10/98-present
Children with Special Needs	Joyce Brooks, MSW	1993-present
Community Services	Eleanor Padgett, LICSW	5/01-present
Policy, Planning and Evaluation	vacant except for 10 month period 02-03	
Adolescent Health	Colleen Whitmore, MSN	9/01-present
Special Initiatives	Felicia Buadoo-Adade, RD	10/03-present

Division directors meet weekly to report on the status of programs and to discuss any issues or program barriers requiring coordination across divisions. Information about the Administration and DOH is shared with management staff during these weekly meetings.

The 2 federally funded Healthy Start projects, which are the largest sources of funding other than Title V, family planning and the home visiting initiative, constitute the family services division. The community services unit includes information and referral, transportation services, and community education. The responsibilities of the special needs division and the data division are described in the section on special needs and other capacity respectively.

The Realignment

The Maternal and Family Health Administration, to be headed by a senior deputy director, is being realigned as 5 bureaus as this application is being prepared. The purpose is to align programs that are population based or service driven and to assure an integrated approach to service delivery. The mission of the Maternal and Family Health Administration continues to be to promote the development of an integrated community based health delivery system, to improve health outcomes, to foster public private partnerships for women, infants, children, CSHCN, adolescents, families (including fathers) and seniors. The realignment becomes effective October 1, 2005. The DOH director is preparing a transition plan.

The Perinatal and Infant Health Bureau is responsible for the federally funded Healthy Start projects, which provides nurse case management for at-risk pregnant women in Wards 5, 6, 7 and 8. Women and their infants are retained in case management for 24 months after delivery, with coordination of well baby care and special needs referrals, contraception and other interconceptional care of the women. This Bureau will also be responsible for the implementation

of a newly awarded 1-year MCHB grant to promote perinatal depression screening and referrals for treatment. In addition, the Perinatal and Infant Health Bureau will operate a number of Title V-funded services and activities, namely the SIDS bereavement and education program and the newborn home visiting program, which includes distribution of free cribs to families that do not have safe sleep arrangements for newborns, and funding of discharge planners in local birthing hospitals. The bureau will also continue to be the liaison to the District's child and infant mortality review functions, currently located in the Office of the Medical Examiner, an office that reports directly to the mayor.

The Child Health Services Bureau /2007/ Children with Special Health Care Needs Bureau // 2007// is responsible for all CSHCN functions--the genetic and metabolic, and newborn hearing screening programs, sickle cell disease program, and the grant-funded awareness and access to care for children with epilepsy. The childhood lead poisoning prevention program, formerly a component of the Environmental Health Administration, will be a new responsibility for this bureau.

The Nutrition and Physical Activity Bureau /2007/ Nutrition and Physical Fitness Bureau//2007// is responsible for the Special Supplemental Program for Women, Infants and Children (WIC) and the administration of other grants funded by USDA--Loving Support Breastfeeding Program (a partnership with Howard University Hospital), Food Stamp Nutrition and Education Program, Commodity Supplemental Food Program, Farmers' Market Nutritional Program, Folic Acid Initiative and the Employee Wellness Program.

The School Health and Adolescent Health Bureau /2007/ Child, Adolescent and School Health Bureau //2007// will be made up of 3 divisions--school health, adolescent health and oral health. The School Health Division, staffed with 1 FTE, is responsible for the school health nursing program (see section on interdepartmental coordination for description), the Woodson Senior High School Wellness Center (funded with Healthy Start grant monies), and the vision screening program, which was formerly conducted by the CHSCN division.

/2007/ The vision screening program remains in the CSHCN Bureau. See other activities section of this application. In addition to this program, the school nurse program includes periodic universal vision screening. //2007//

The Adolescent Health Division will have responsibility for the grant-funded abstinence education program, the TANF-funded teen pregnancy prevention program, and 2 programs that will continue to be supported by Title V monies--youth violence prevention, and the health and sexuality education initiative. Oral health activities are being placed in the Oral Health Division, staffed with a public health dentist. Division responsibilities include directing a federal grant--oral health integrated system development--to rebuild the structure for a state oral health function, including the formulation of standards for school based oral health services and child oral health assessment and the operation of a small school based dental sealants project. Another oral health grant, in its final year but with substantial funds available for carry over, has been used to work in conjunction with CNMC to establish oral health services at 2 public schools dedicated to CSHCN, and to use telemedicine to extend such services to other schools serving high numbers of CSHCN.

/2007/ The teen pregnancy prevention program (Teen Mothers Take Charge) is Title V-funded. Local funds have been appropriated to expand the program in FY 2007. //2007//

The 5th bureau, the Adult and Family Health Services Bureau, will be responsible for the men's health initiative, the women's health initiative and family planning, which are currently a part of the Administration's special initiatives division. The bureau will be responsible for transportation, as well as a sexual assault prevention program that is being transferred from the Primary Care and Prevention Administration.

The status of the MFHA Data Analysis and Program Evaluation Division is uncertain, pending further review at the departmental level and by the new Senior Deputy Director of the Maternal and Family Health Administration. Decisions about the assignment of nutritional services and lead poisoning prevention surveillance positions have yet to be announced.

/2007/ The surveillance positions remain in the respective bureaus. //2007//

Incumbent division directors have been informed that they must apply for the positions of bureau chiefs. However, the new positions are at a higher grade and therefore not all directors are eligible to apply for the positions in which they are currently functioning.

/2007/ The realignment described above officially became effective December 2005 with slight changes in the names of these bureaus. The following bureau chiefs have been appointed.

Perinatal and Infant Care Bureau	Vacant as of June 22, 2006
Child, Adolescent and School Health Bureau	Colleen Whitmore, MSN, CFPN
Nutrition and Physical Fitness Bureau	Michele Tingling-Clemmons
Adult and Family Health Services Bureau	Paula Marshall, MA, MHS, CPM
Children with Special Health Care Needs Bureau	Interim, Joyce Brooks, MSW //2007//

/2008/
The Realignment
The former Maternal and Family Health Administration and the Primary Care and Prevention Administration were realigned as the Maternal and Primary Care Administration. Gregg Pane, M.D., Director D.C. Department of Health approved this realignment on January 17, 2007. Carlos Cano, M.D., was appointed as the Senior Deputy Director. This is a functional realignment that is not reflected in the FY 2007 budget and new budget structures will not occur until FY 2009. See the attached organizational chart.

The mission of the MPCA is to improve health outcomes for all residents of the District with an emphasis on women, infants, children (including CSHCN) and other vulnerable groups such as those with a disproportionate burden of chronic disease and disability. To this end MPCA provides programs and services to promote coordination among the health care systems of the city and enhance access to effective prevention, primary, and specialized medical care. MPCA also collaborates with public and private organizations to provide support services to ameliorate the social determinants of health status for these groups. MPCA embraces the values of accountability, collaboration, and initiative in the pursuit of our mission and foster public participation in the design and implementation of our programs.

The MPCA is part of the DC DOH, and is the District's Title V agency. As of May 2007, the MPCA consists of a Senior Deputy Director, a Chief of Staff, and three new offices under the Senior Deputy Director: Office of Program Support Services, Office of Grants Monitoring and Program Evaluation, and the Office of Health Care Access and Clinical Services. The Lead and Environmental Hazards Bureau is a new Bureau. The Adult and Family Health Bureau was eliminated and staff were reassigned to other Bureaus. The following eight Bureaus comprise the Administration:

Children with Special Health Care Needs Bureau, Joyce Brooks, MSW, Chief.
Child, Adolescent, and School Health Bureau, Colleen Whitmore, MSN, FNP, Chief.
Perinatal and Infant Health Bureau, Karen Morris, M.D., Chief.
Nutrition and Physical Fitness Bureau, Michele Tingling-Clemmons, Chief.
Lead and Environmental Hazards Bureau, Pierre Erville, Chief.
Cancer and Chronic Disease Prevention Bureau, Emanuel Nwokolo, PhD, Chief.
Communicable Disease Control Bureau, Karyn Berry, M.D., Chief.
Bureau of Pharmaceutical Services, Gisele Sidbury, Pharm.D, Chief.

The major priorities of the MPCA are to reduce infant mortality rates, enhance the MPCA's data gathering and analysis systems, and improve access to primary and specialty care (medical homes) for underserved populations including children with special health care needs. MPCA is focusing on developing programs that contribute to a lower infant mortality rate and enlarging public participation in the Title V program. MPCA also will work more closely with the District's community-based organizations to achieve these goals. The ultimate goal of the Title V program will be to improve national and District performance measures and reduce disparities with respect to resident health outcomes.

The DC DOH is responsible for the administration and supervision of programs carried out with allotments under Title V, Section 509 (b). This is done under the supervision and direction of the Senior Deputy Director. The following programs funded by the Federal-State Block Grant Partnership include:
Direct health care services (basic health services and health services for CSHCN.
Enabling services (transportation, translation, outreach, respite care, health education, family support services and purchase of health insurance, case management and coordination with Medicaid, WIC, and education).
Population-based services (newborn screening, lead screening, immunization, Sudden Infant Death syndrome counseling, oral health, injury prevention, nutrition, and outreach/public education).
Infrastructure building services (needs assessment, evaluation, planning, policy development, coordination, quality assurance standards development, monitoring, training, applied research, systems of care, and information systems).

This section includes an organizational chart for MPCA as an attachment. //2008//

/2009/ This year the DOH experienced two major organizational events. Under the direction of the Director of Health, Dr. Gregg Pane, DOH was realigned to form seven administrations. The realignment reduced the number of DOH administrations from 11 to seven, reallocated staff to a new procurement and grants management function, and created a new focus on performance accountability. The new DOH operational structure incorporates many of the recommendations from DC Mayor Adrian Fenty's Pre-Transition Health Team. The primary changes included 1) the integration of the Bureau of Epidemiology and Health Risk Assessment with the State Center for Health Statistics and the State Health Planning and Development Agency to create a Center for Policy, Planning and Epidemiology. 2) Changing the name of the Maternal and Primary Care Administration to the Community Health Administration (CHA). This Administration is responsible for the Office of Grants Management and Program Planning, Perinatal and Infant Health Bureau, CSHCN Bureau, CASH Bureau, and the Nutrition and Physical Fitness Bureau. A copy of CHA's organizational chart is enclosed as an attachment. In October 2008 the Lead Program moves to the District Department of the Environment.

In March 2008 Mayor Fenty named Pierre N.D. Vigilance, MD, MPH as Director of DOH. Dr. Viligance served as the director and health officer of the Baltimore County Department of Health since 2005.

Other significant staff changes within the Community Health Administration include assignment of Charles Nichols, MPP, Chief, Grants Monitoring and Evaluation and Nathaniel Beers, MD, Deputy Director of Policy and Planning. Brief biographical sketches of Mr. Nichols and Dr. Beers are enclosed as an attachment.

Dr. Cano continues as the Senior Deputy Director of the CHA and fully supports and advocates CHA's overarching goal to improve the health and well being of residents by reporting, investigating and controlling communicable diseases, prevention of chronic diseases and their complication, and engaging in health care system planning to meet the service needs of the population. CHA focuses on carrying out the Mayor's initiatives to reorient the health care system

toward community-based prevention, primary care, and keeping citizens healthy. //2009//

/2010/ The major changes within CHA are: the realignment of CHA to include the disolution of a stand alone Special Health Care Needs Bureau and its integration of its activities to either CASH or the Perinatal and Infant Health Bureau well defined in Agency Capacity. This change decreased the perceived "silo" effect among the Bureaus. It also allowed CHA to decrease personnel costs due to redundant activities among staff. The change supports the inclusion of special needs children within each of the Bureau's perinatal, infant and children and adolescent activities.

Another change is the resignation of Dr. Carlos Cano in May 2009. DOH has initiated steps for recruitment. At this time Ms. Sandra Robinson was named as the Interim Senior Deputy Director.

As of July 3 Dr. Nathaniel Beers resigned from CHA to assume the position of Executive Director of the Early Stages Program at DCPS. HRSA informed DOH that the Title V Director position is required to be an employee of DOH, therefore Dr. Beers will not be able to continue his relationship with the program and the CSHCN Advisory Board. Mr. Charles Nichols will be the Title V Project Director. A copy of the current CHA organizational chart is included in this section.

Updates in administration positions within CHA include the hiring of Alvaro Simmons, M.ED, MSW, LSCW to lead the CASH Bureau and Joanne Lynn, MD, to lead the Cancer Prevention and Chronic Disease Bureau. Lauren Ratner, MPH, MSW, as Bureau Chief for Primary Care within the CHA. Brief resumes for Dr. Lynn, Ms. Ratner and Mr. Simmons are attached. //2010//
An attachment is included in this section.

D. Other MCH Capacity

Title V funds the majority of the data collection and analysis division 4 of which hold masters degrees. The project activities carried out in the division include Healthy Start evaluation, Pregnancy Nutrition Surveillance System (PNSS), Pregnancy Risk Assessment Monitoring System (PRAMS), birth defects registry, ECCS grant data collection, and the SSDI grant, which supports various database linkages and integration efforts. Management information systems is being reassessed throughout the department by a needs assessment process to evaluate existent data systems and staffing Concern aroung costs and relevant benefits of existent and developing surveillance, tracking, and websites exitst including PRAMS and PNNS, Healthy Start MIS, DC Kids Link, UNITS the newborn discharge program, and for the birth defects registry, and the school health information system.

/2007/ PRAMS, PNSS, and the birth defects registry were discontinued in 2006 due to the inability to obtain appropriated funds to replace federal funding. The pilot project in the schools was halted because of the next MIS system to link school and school health data.
Currently, DOH surveillance functions are decentralized and scattered throughout the organization. At issue is merging data functions. DOH will assess existent and future staffing patterns. Web-based applications and data warehousing. MFHA expects to hire a data unit coordinator this summer to complete a data needs assessment and to make recommendations on the most effective organizational structure for the data unit. MFHA management is holding discussions with CDC and MCHB to support the assignment of a senior epidemiologist.

At least 10 Administration staff members parent children with special needs. These staff were not necessarily hired to advocate for the special needs population; their responsibilities are integrated throughout the functions of the Administration. Marilyn Seabrooks Myrdal, the Administration's representative to AMCHP, represents AMCHP on the Family Leadership Caucus, a group formed to advice and guide AMCHP and state Title V programs regarding the roles and responsibilities of

families. The grant to enhance access to services for children with epilepsy will fund a family advocate to be located with each of the 4 Medicaid MCOs. In 2004, the MFHA dedicated a position for Hispanic Health Services.and hired a bilingual registered nurse and health educator who organized an Hispanic Health Coalition of representatives from community based organizations in the Latino community ultimatel to advise on the needs of the Latino MCH population.

/2008/ The Hispanic Health Services position and the Hispanic Health Coalition are no longer in place.
Another MFHA employee, hired as a liaison to the Asian and Pacific Islander community, speaks Mandarin, Cantonese and Vietnamese. The DOH has formed an office of language and communications in order to comply with the recently passed language access law. to arrange for translation of departmental materials.

Title V programs staff based upon the current budget structure is listed
Bureaus and Offices (Title V FTEs):

Adult and Family Health: 20
Child, Adolescent and Health Bureau: 10
Children with Special Health Care Needs: 17
Nutrition and Physical Fitness Bureau: 5
Perinatal and Infant Health Bureau: 6
Office of the Senior Deputy Director: 12.34

Carlos Cano, M.D. was appointed Senior Deputy Director of the Maternal and Family Health Administration centered on iimproving the life of infants, young children, and mothers by improving life expectancy and other health measures.

Sandra Robinson was named the Chief of Staff, MPCA in April of 2006. Previously, she was Director of the Center for Workforce Development, District of Columbia Office of Personnel; Program Manager of the District of Columbia Office of Contracting & Procurement; Project Director of TONYA, Inc.; and Manager, Division of Human Resource and Organization Development, District of Columbia Department of Housing and Community Development. She has a master's degree in Project Management from the School of Business and Public Management, The George Washington University.

The new Bureau Chief of Perinatal and Infant Health is Karen Morris, M.D. and the new Bureau Chief of Lead and Environmental Hazards is Pierre Erville. In order to improve MPCA's capacity to collect, acquire, analyze and utilize program data and strengthen surveillance systems, Stephanie Alexander was hired as Chief of the Data Analysis and Program Evaluation Division.

MPCA is collaborating with the city's Office of the Chief Technology Officer (OCTO) to develop an integrated data management system. OCTO will analyze the current business practices and the data linkages needed to support the system under a Medicaid Transformation Grant for data integration. In time, MPCA plans to link its data-bases to the Medicaid Information System as well. The long-range goal will be to link MPCA to the Safe Passages System to identify and improve the coordination of all services in which a child is enrolled.

The Center for Disease Control and Prevention assigned Dr. Genet Burka, a medical epidemiologist to assist in the investigation of the District's high infant mortality rate. Both Dr. Burka and Ms. Alexander will be conducting a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. MPCA was selected to participate in a year-long Data Institute Initiative sponsored by City Match Urban Leadership Institute for Maternal and Child Health. The data unit will evaluate the effectiveness of the Safe Start: Cribs for Newborns Program whose aim is to assist in reducing the infant mortality rate by providing cribs, mattresses and education on safe sleeping practices to mothers,

guardians and caregivers.

The CSHCN Bureau has sent two managers to the Maternal and Child Health Leadership Skills Training Institute. to study (1) Planning, Implementing and Evaluating Programs (PIE) and (2) leadership skills required to address the growing need to coordinate and integrate with programs outside of the current Title V domain.

The MPCA has been an active participant in the Regional Conference Calls hosted by the Association of Maternal and Child Health Programs (AMCHP). MPCA was a partner in the planning process with the other Region III states for the annual AMCHP conference. The conference was held March 3-7, 2007 in Washington, DC. The District participated in the Regional Roundtable at the Conference, wherein MCH and CSHCN leaders came together to provide updates on their respective state activities, and highlight programs that merit national attention. //2008//

/2009/ In March 2008 Mayor Fenty named Pierre N.D. Vigilance, MD, MPH as Director of the DOH. Dr. Vigilance, a veteran public health leader, leads a team of experts including Dr. Carlos Cano, who skillfully ran DOH during the interim period prior to the naming of the permanent director. His goal is to keep human service agencies focused on the target populations in greatest need. As the director and health officer of the Baltimore County he led an agency of 500 staff covering a jurisdiction of approximately 800,000 residents and a $50 million annual budget. He established a quantitative management reporting system to improve performance management and was responsible for improving access to care for the medically uninsured by increasing the number of Kaiser Permanente "Bridge" program slots from 300 to 525 (75%) in just two years. He has been instrumental in local legislative changes aimed at reducing youth access to tobacco and has been a collaborator with the Johns Hopkins University Bloomberg School of Public Health to provide regular applied public health internship opportunities.

Charles Nichols, MPP, Chief, Grants Monitoring and Program Evaluation, has more than 14 years experience with the Department of Health. His major areas of responsibilities include: 1) Grants Monitoring and staff oversight related to approximately 40 federal grants and 20 awards made to local community partners to ensure compliance with all applicable federal and District grant circulars, laws, policies and regulations. 2) Program Administration management activities related to the program implementation of the Preventive Health Services Block Grant, the Maternal and Child Services Block Grant, State Systems Development Initiative Grant, and the Traumatic Brain Injury Grant through the supervision of the respective program coordinators. 3) Resource Development activities that include identifying funding opportunities, coordinating the development of grant proposals, and providing quality assurance through direct supervision of the process and internal approval. 4) Program Evaluation activities that include development of a system within the Administration to use program evaluation techniques including the analysis of data to improve the effectiveness of program initiatives. Responsibilities also include supervision of Supervise a team of public health analysts. Mr. Nichols received is AB, Government and Economics from Georgetown University, and a Master of Public Policy from The University of Michigan.

Nathaniel Beers, MD, a board certified developmental behavioral pediatrician, is the Deputy Director of Policy and Planning. He previously served as the Medical Director of the Children's Health Center, Children's National Medical Center. Dr. Beers has more than 9 years of experience in the field of children with special health care needs with a strong interest in children with disabilities, obesity, behavioral disorders, immuniztions, school health and public health and policy. He has also published a comprehensive analysis of Title V programs and the effects of different ssystems on funding. He is President of the DC Chapter of the American Academy of Pediatrics.

Dr. Beers received his B.S. from the University of Rochester; M.D. from The George Washington University, School of Medicine and Health Sciences; MPA from Harvard University, John F.

Kennedy School of Government; Clinical Effectiveness Certificate Program, Harvard University, School of Public Health; and Certificate in Leadership in Human Resource Development from The George Washington University, School of Education and Human Development.

CHA is responsible for the management of the Title V Maternal and Child Health Block grant. The programs funded through the Title V Block Grant and discussed in the application are managed by the Perinatal and Infant Health Bureau, Child, Adolescent and School Health Bureau, Special Health Care Needs Bureau and Nutrition and Physical Activity Bureau.

The full time equivalents (FTEs) positions supported by Title V funds include:
Administration (includes Grants Management and Evaluation, Finance, Data Anaysis, etc.) - 26 FTEs
Perinatal and Infant Health Bureau - 12.5 FTEs
Children Adolescent School Health Bureau (includes Oral Health Program)- 11 FTEs
Other Federal grants fund staff positions that support Title V.

The Lead Program will move to the District's Department of the Environment (DDOE) in October 2008. Funds previously utilized to fund staff positions will be used to support Title V programs. The Program will continue to provide lead screening and home assessments of children with blood lead levels = or > than 5 ug/dL. Funds will be allocated to support lead screening for uninsured District children. //2009//

/2010/ CHA has hired several key personnel:
Mr. Alvaro Simmons was named the Bureau Chief of the Child, Adolescent and School Health Bureau and joined the CHA staff in April 2009. His resume is enclosed in the Section Agency Capacity.

Joanne Lynn, MD was named Bureau Chief of the Cancer and Chronic Disease Prevention Bureau. Dr. Lynn's recent experiences include being the Director of the Washington Home Center for Palliative Care Studies and Medical Officer at the Centers for Medicare and Medicaid Services, and currently is a Senior Researcher, RAND Health, Center to Improve Care of the Dying.

Lynda Williams joined the staff of the Office of Grants Management and Program Evaluation in May 2009 as public health analyst. She has 15 years of public health/evaluation/data management experience. She led a team to change Oklahoma's ambulance data collection system to conform to national standards. She served as program specialist on two HRSA sponsored HIV/AIDS prevention, treatment and outreach projects directed to Hispanic and American Indian/Alaskan Native communities. She has worked on Emergency Medical Services, Family Planning, Maternity, and Vital Statistics data systems, as well as assisting in the analysis of the Youth Risk Behavior Survey and is familiar with the Title V block grant.

Lauren Ratner, MPH, MSW currently serves as DOH's Bureau Chief for Primary Care within the Community Health Administration. In this role, Ms. Ratner serves as the Primary Care Office (PCO) Director with oversight of the District's health professional shortage area (HPSA) designation processes and primary care workforce recruitment and retention responsibilities including those related to the National Health Service Corps, J-1 Visa Waivers, the Health Professional Recruitment Program (DC's student loan repayment program) and DC's pipeline and allied health programs. In addition, Ms. Ratner oversee the award and implementation of grants to provide health services at publicly owned or leased properties in DC's Wards 7 and 8, grants totaling over $50 million from Tobacco Settlement Funds for health center capital expansion projects and the development of a regional health information organization (RHIO), and the District's Refugee Health Program.

The Full Time Equivalent (FTEs) positions supported by Title V funds for 2010 include:
Administration (Office of Senior Deputy Director includes Grants Management and Evaluation, Finance, Data
Analysis, etc.) -24.5 FTEs
Perinatal and Infant Health Bureau -18 FTEs
CASH Bureau - 12 FTEs
Total FTEs: 64.5

The Children with Special Health Care Need Advisory Board was the subject of our Technical Assistance this year. Membershp was increased two fold from February 2009 to July 2009; from 11 members to 22 members. Technical assistance was provided by Dr. Michela Perrone of MPP Associates who strengthened the board by performing an organizational assessment. Shortly after new elections were held, the new officers and Dr. Perrone developed a strategic plan that would drive the board in the next year. Three main committees would be formed. Mary Frances Kornak remains as the CHA liaison to the board. The Advisory Board will assist CHA in the revision and developmenty of a new CYSCHN strategic plan

//2010//
An attachment is included in this section.

E. State Agency Coordination

Intradepartmental Coordination

Coordination with Medicaid-SCHIP
Administration efforts to establish formal relationships with its sister agency--the Medical Assistance Administration--and the Medicaid managed care organization (MCO) contractors. By December 2004 the 3 MCOs and the CSHCN carve-out MCO had signed MOUs outlining the respective responsibilities of the MCO, MAA and the Administration. The agreements focus on the care coordination and continuity of care for those MCO enrollees who are also Administration clients, including but not limited to Healthy Start participants. It is expected that in FY 2006, representatives will begin work on case management standards and protocols.

Prior to the MOU, Administration employees were trained on procedures for referring potentially eligible persons to Medicaid-SCHIP enrollment sites. Healthy Start nurse case managers work to enroll and maintain certification of their clients, assist with selection of a primary care provider, instruct how to use a managed care provider--medical home.

/2007/ See state performance measure 2. //2007//

Substance Abuse
The Administration negotiated an MOU with its sister agency, the Addiction Prevention and Recovery Administration (APRA), March 2003 to use Healthy Start funds to provide pregnancy test kits for women who present for substance abuse services at the Women's Services Clinic and other APRA-operated facilities. Pregnant women, as well as women up to 3 months postpartum, are referred to Healthy Start for case management. The 2 agencies established a reciprocal referral system, and a jointly funded paraprofessional health education position located at the Women's Services Clinic to coordinate referrals, joint case conferences and staff training.

HIV/AIDS Coordination
As a result of participation during 2001-2002 in a special CityMatCH project, the Perinatal Urban Learning Cluster, and later in the Association of Maternal and Child Health Programs (AMCHP) Perinatal HIV Transmission Action Learning Lab, the Administration strengthened its relationship with its sister agency, the HIV-AIDS Administration (HAA), and the Ryan White Title IV grantee to develop a policy statement on perinatal transmission. In 2003, a CDC representative met with

the Clinical Advisory Workgroup and DOH staff to discuss the implications of rapid testing technology on perinatal HIV control. CDC met with HIV/AIDS Administration, APRA and a panel of 6 District physicians to prepare the March 2003 Final Draft Revised Recommendations for Universal HIV Screening of Pregnant Women. Recommendations included the incorporation of routine HIV testing as a normal part of prenatal care, including universal retesting in the 3rd trimester and "opt-in" or" opt-out" protocols. www.hivatis.org (currently http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=66).

/2007/ MFHA is working with a sister agency, the Administration for HIV Policy and Programs (AHPP), formerly named the HIV/AIDS Administration, on the implementation of a CDC perinatal HIV prevention grant. The prevention plan includes HIV testing for pregnant women; training for providers regarding perinatal and HIV prevention, pediatric care and treatment services; and access to medications through the AIDS Drug Assistance Program (ADAP).

Work is underway with an internal DOH workgroup to agree on and disseminate prenatal testing standards and policy based on those in place in New Jersey. The group is reviewing existing counseling, testing and referral (CTR) policy to incorporate prenatal opt-out and HIV-exposure reporting for newborns. Pending a MOU, the perinatal prevention grant may also support co-location of CTR and case management with Healthy Start case management. Such an arrangement was funded in past years but then lapsed.

Also several District hospitals have participated in a CDC-sponsored study to determine prenatal HIV-testing rates through medical chart review to create a baseline for targeting provider and facility training on prenatal HIV testing standards.

On June 19, 2006 in commemoration of National HIV Testing Day, AHPP kicked-off a campaign to encourage all District residents, ages 14 to 84, to be screened for HIV and know their HIV status. Those who test positive are to be immediately referred to counseling, medical care, and treatment. DOH has purchased 80,000 rapid testing kits for distribution to hospitals, clinics, physicians, and community testing sites. The announcement of the campaign follows a period of considerable advocacy activity and public scrutiny of HIV programs in response to the high rate of AIDS cases in DC. In 2004 the rate was 179.2/100,000, the highest among cities with a population in excess of 500,000. //2007//

Interagency Coordination

Coordination with various agencies is discussed throughout this application-- in the overview as well as the annual report/annual plan sections.

Coordination with Public School System
DC public schools are required by the District of Columbia Public School Nurse Assignment Act of 1987 to staff a minimum of 20 hours per week of nursing services in public schools. High schools are to have a registered nurse or LPN on duty at least 40 hours per week. The operation of the school nurse program has undergone a number of changes over the past 10 years. The Department of Health (then the Commission of Public Health) operated the program, with nurses employed directly by the commission. In the late 1990s the DC Health and Hospitals Public Benefits Corporation (PBC) was responsible as well as for the operation of the DC General Hospital and the public community health centers. The PBC was abolished and safety net system was privatized in 2001. The District contracted with the Children's National Medical Center, a tertiary care institution, to operate the school nurse program. The DOH Safety Net Administration was created to oversee the entire privatization effort and contracts, with the Maternal and Family Health Administration retaining some responsibilities for school nursing policy and standards development, evaluation and monitoring.

The advent of charter schools during this period increased the cost burden insofar as charter

schools are eligible to request school nurse services; but 36 of 57 charter schools do not have the required nursing services. Additional local funds were requested in the FY 2006 budget to meet this demand; partial funding was approved.

In 2004, the Administration hired a masters-prepared registered nurse to support coordination with the schools and the school nurse program. She is in the new Adolescent and School Health Bureau, School Health Division. The proposed FY 2006 budget includes funds to provide additional school health services.

The school health liaison also represents the Administration on the city wide Task Force on Immunization. In past years, DOH has had to redeploy staff at the beginning of the school year to staff express clinics and track down children whose immunization records were not up to date. Schools have denied admission to students who were not in compliance with immunization requirements; however, it appears that the annual "immunization crisis" will be avoided this September: 90% of the schools have > 90% of students properly immunized.

The school health liaison is in daily contact with the school health nurses program regarding the reporting and resolution of incidents and urgent issues, for example, nurse coverage of schools to meet legal requirements, particularly at the beginning and end of the term. Schools have very different needs based upon location, enrollment, and socio-demographic characteristics of the students and neighborhoods, and the numbers and needs of medically fragile students who have been mainstreamed.

It is not uncommon for a medically fragile child to transfer in without notice and the necessary resources in place to meet her/his needs for nursing support. Not all school nurses have recent training sufficient to meet specific, individual needs. The school health liaison must ensure the needs of medically fragile are met.

In spring 2005, the Adolescent and School Health Division implemented a systematic school health monitoring protocol, which supplements the monitoring of the physical facilities and equipment in the school nurse suite conducted by the Safety Net Administration. The inadequacy of the space, equipment and Internet access of many school nurse suites has been noted and efforts are proceeding to incorporate standards published by the National Association of School Nurses.

/2007/ See the overview section for recent advances in interagency coordination on school health. //2007//

Mental Health Coordination
In March 2001, the Administration, through the Healthy Start program, set the stage for an important collaboration with the Commission on Mental Health, now the Department of Mental Health (DMH). The Parent and Infant Development Program (PIDP), located in the Children and Youth Services Administration, DMH, provides outpatient evaluations, psychiatric, psychological and psychotherapeutic services to pregnant women, their families and children up to age 5. An MOU with the PIDP DMH was signed February 2003 and Healthy Start funds were transferred to pay 2 LICSWs to case manage referrals of Healthy Start clients who screen positive for depression and/or appear to have other mental health disorders. The Administration worked with Mary's Center for Maternal and Child Care (a 330 grantee) to submit on June 2, 2004 a grant application to MCHB for a 1-year program to introduce perinatal depression screening throughout the District of Columbia. Notice of grant award for $250,000 received spring 2005. Implementation October 2005.

The MFHA is among the many government agencies participating in a private-public partnership to improve learning outcome for young children through the alignment of programs for children ages 3 -- 6 and transition between preschool and school. 10,000 of the 16,000 3-4 year olds are estimated to be enrolled in some type of early education programs, but fewer than 33% attend a

program accredited by the National Association for the Education of Young Children. 3 large child development centers have been selected as anchor sites in each of Ward 1, 7 and 8. Each anchor is paired with an elementary school and staff and parents will adapt and implement preschool-school transition strategies affecting 1000 preschool children. MFHA is to coordinate the 6 schools in the school health information automation pilot project. See NP# 7. In 2005, the partners worked to develop universal standards for school readiness for 4 year olds.

Family Services
The Administration and the Child and Family Services Administration (CFSA), Department of Human Services, negotiated a memorandum of understanding (MOU) effective December 2002 through September 2004 (signed April 23, 2003) for joint case management of drug exposed infants. The MOU was developed in response to the varying practices in hospitals for reporting "substance-positive infants" and the Child Fatality Review Committee's long standing recommendation to improve and coordinate home visiting services to high risk families. Through the Administration's home visiting program, many substance using families are identified and targeted for continued assessment and treatment; however once the infant leaves the hospital, many refuse follow up services. The joint case management incorporates the Administration's skilled nursing assessment and related services by Healthy Start nurses and the CFSA's family focused case management. Law 14-206 Improved Child Abuse Investigations Amendment Act of 2002 strengthened the District's investigations of child abuse and neglect. Among other provisions, the law changes the definition of child neglect to include drug exposure and positive drug test in newborns and requires reporting of positive drug tests. But the language does not mandate a finding of neglect based on drug exposure alone. The legislation was not supported by dedicated funding for implementation.

During 2004-2005, due to the influx of these cases, Healthy Start nurses reached and exceeded their caseloads, reducing the resources for prenatal and interconception care coordination as required by the Healthy Start grant. A new MOU that requires CFSA to provide funding for 2 FTE Healthy Start nurse case managers to ease the workload is ready for signature.

/2007/ The CFSA fudning was not realized.

MFHA recently issued a subgrant to Mary's Center to develop a pilot program to screen high risk mothers, including those who use substances, and conduct assessments and nurse home visits after discharge from the hospitals. The agreement also includes training of MFHA staff to augment case management capacity in the community. //2007//

Other collaborations and coordination of activities are described in the performance measures sections of this application.

/2008/ MPCA has established many internal and external collaborative efforts.

Intradepartmental Coordination

The CSHCN Bureau is currently working in collaboration with the Child, Adolescent, and School Health Bureau's Oral Health Division and the managed care organization HSCSN to create a task force and action plan to improve the oral health of children and youth with special health care needs.

MPCA jointly participates with the Addiction Prevention and Recovery Administration's (APRA) in the Pregnancy Identification Intervention Strategy Program with the Addiction Prevention and Recovery Administration's (APRA) Central Intake Unit. Ultimately the goal is to improve the system of care for pregnant and post-partum substance abusing women and reduce infant mortality in the community by enrolling more women in the DC Healthy Start program.

The school health liaison represents the MPCA on the citywide Task Force on Immunization. The

current immunization compliance rating for the District of Columbia Public Schools is almost 98%.

Interagency Coordination

MOUs

The Perinatal and Infant Health Bureau has a multi-year Memorandum of Understanding with the Department of Mental Health's Parent Infant Development Program (PIDP) for the Healthy Start Project staff to provide mental health counseling and support to pregnant and parenting women who may be at-risk for depression. Interagency conferences are held bi-weekly between PIDP and Healthy Start staff to exchange information and plan care.

DC DOH will enter into an MOU with the State Education Office, Nutrition Services Department in order for MPCA to provide an intensive, comprehensive nutrition education and physical activity training program for District of Columbia child care providers.

DC DOH and the DC Public Schools will enter an MOU in order for the DC Public Schools to allow the MPCA, Rape Prevention and Education Program's sub-grantee, Men Can Stop Rape, Inc. to provide sexual violence prevention education training sessions to male students attending DC public schools.

Programs

MPCA collaborates with the District of Columbia Public Schools on an ongoing basis to implement the District of Columbia Public School Nurse Assignment Act of 1987 in order to staff a minimum of 20 hours per week of nursing services in public schools. In FY 2006, there were 141,030 student visits to the health suites. To date in FY 2007, there are 103,897 student visits documented.

MPCA is in the process of ensuring that all health suites are provided with computers and wired for Internet connectivity. The Bureau plans to ensure that virtually all health suite have network connectivity by FY 2008.

The Perinatal and Infant Health Bureau/DC Healthy Start Project in FY 2008 plans to enter into a collaborative agreement with the Child and Family Services Administration to expand home visitation in DC, provide referrals, home-visits, and monitoring and supportive services from a family support worker for familied with children aged 2-5.

MPCA staff serve as members of the Child Fatality Review Committee, a city-wide collaborative program authorized by the Child Fatality Review Committee Establishment Act of 2001 examine the circumstances that contributed to the deaths of infants, children, and youth who reside in the District.

The Perinatal and Infant Health Bureau/DC Healthy Start Project has a multi-year (through December 31, 2009) sub-grant agreement with the Healthy Babies Project, Inc. to expand case management/care coordination services to 105 high-risk pregnant and parenting women residing in Wards 5 and 6.

The District has made changes internally to develop and implement a vigorous enforcement program to ensure compliance on all lead-related legislation, regulation and standards.

The CASH Bureau plans to increase the number of schools receiving 40 hours of nursing coverage to 75% in FY 2008 with additional resources authorized by the Council of the District of Columbia. The Child Adolescent and School Health Bureau also plans to collaborate with the Bureau of Communicable Disease's STD program to launch a school-based STD urine screening project in area high schools to contain and reduce the escalating rates of Chlamydia and

gonorrhea in the adolescent population.

In July 2006, the Nutrition and Physical Fitness Bureau (NFPB), Food Stamp Nutrition Education Program staff provided nutrition education to the Department of Parks and Recreation's Healthy Kids Camp, where adolescents received both nutrition education and fitness instruction to guide them on a long-term program to improve their health. Starting in October 2006, NPFB has participated with Summit Health Institute for Research and Education on its development of a Childhood Obesity Collaborative for Ward 8, East of the River.

In 2006, between May and November, the Farmers' Market and Senior Farmers' Market Nutrition Programs to ensure that the maximum distribution, redemption, and use was made of the coupons provided to each Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Commodity Supplemental Food Program participants.

The District of Columbia Metropolitan Police Department has a Sexual Assault Unit that partners with DOH on pursuing grants, as well as providing sexual assault data in the District.

External Partnerships

The MPCA funds three grants to the DC Primary Care Association to assist in the creation of medical homes for underserved populations in the District. On grant is funded through the HRSA Medical Homes Initiative.

The MPCA awarded $125,000.00 to So Others Might Eat (SOME) and $100,000 to Howard University College of Dentistry to treat and improve the oral health of vulnerable District residents.

The CSHCN Bureau helped to improve family utilization of a community-based service system by collaborating with the four Medicaid MCOs to hired parent advocates to help families enrolled in their respective plans and navigate the health care delivery system.

MPCA was selected among 18 other states to participate in the Assuring Better Child Health and Development Screening Academy project and receive technical assistance to integrate valid, standardized tools of children's development into preventive health care practice.

The Childhood Lead Poisoning, Screening, and Education Program (CLPSEP) has an on going subcontract with Lead Safe Babies of the National Nursing Center Consortium (NNCC) to provide in-home screening and education for 400 pregnant and new mothers in high-risk areas.

The CSHCN Bureau has established a Memorandum of Understanding with Howard University Hospital called the District of Columbia Greater Access to Pediatric Sickle Cell Services Project (DC GAPS). The goal of this partnership is to improve education and outreach to children with sickle cell disease and their families.

The Perinatal Infant Health Bureau, in collaboration with Healthy Families Thriving Community Collaborative Council (HFTCC) has implemented a neighborhood-based family support system to sustain a seamless network of community partners throughout the District of Columbia that builds strong families and supportive communities.

The University of the District of Columbia partners with the MPCA to deliver sexual violence prevention education to the UDC student and personnel population as well as staff and students of a university consortium including American University, Georgetown University, George Washington University, the Catholic University of America, and Gallaudet University.

The District of Columbia Rape Crisis Center is also supported by MPCA to deliver sexual violence prevention information to various populations in the District of Columbia.

Family Support Services Division staff participates and provide expertise to the Family Shelter Collaboration on issues of homelessness and related housing and lack of employment opportunities.

The Vision Screening program collaborates with the Lions Club to provide services to children from one to six.

The DC Healthy Start Project and The DC American Lung Association formed a partnership in January 2007 to promote tobacco cessation.

MPCA also supports the DC Control Asthma Now (DC CAN), a public-private partnership to improve health outcomes and reduce the burden of asthma in DC.

The MPCA also collaborates with the National Capital Asthma Coalition, a major regional resource for asthma training for children, adults, and professionals, which includes an Asthma Friendly Schools Training and Awards program known as Everybody BREATHES (Breathe Right, Exercise, and Take to Heart Eating Smart).
//2008//

/2009/ The Community Health Administration (CHA) continued as well as established many internal and external organizational relationships throughout the District to enhance the capacity of the Title V program.

Within CHA, the coordination efforts are reflected in the Perinatal and Infant Health Bureau's partnering with sister Bureaus, such as SHCNs and CASH to ensure that screening and identification of at-risk families is widespread to increase enrollment in prenatal care and home visitation programs. Healthy Start's nurse case managers and family support workers link high-risk women to needed care provided by sister agencies, including tobacco cessation, substance abuse treatment, HIV screening and care, and other services.

Bidirectional referrals of pregnant or parenting women occur between Perinatal and Infant Health Bureau among
APRA, HAA, DMH, DHS, CFSA administrations.

Medical Assistance Administration (MAA)
The Bureaus work closely with MAA to identify opportunities to enroll women and children; improve the health of children and address the state priorities. Efforts include: lead screening and reporting of newborns lead blood level results and obesity in children projects.

Other State Agency coordination include:
HAA conducted sexually transmitted disease screening in several DCPS high schools. The screening was highly successfully and will be expanded to all high schools in 2009.

Department of Corrections (DOC)
The PIHB collaborates with DOC to provide educational programs on parenting skills and safe sleep practices to women incarcerated in the DC Jail.

Child and Family Services Administration (CFSA)
The SHCN Bureau coordinates with the CFSA to identify children with disabilities and developmental delays and assist with access to care.

Obesity Interagency Work Group
CASH Bureau with support of the Nutrition and Physical Fitness Bureau convened the DC Obesity Inter-Agency Work Group in October 2007 and is comprised of more than 15 inter and intra agencies, consumer groups, schools and community based organizations, DC government agencies and CBOs. Its purpose is to gather information about nutrition, physical activity and

obesity prevention activities of DC government. DC Public Schools (DCPS)

The CASH Bureau works in concert with the DCPS and Charter Schools: 1) oversight of the school nurse program; 2) father/son and mother/daughter programs; 3) health education sessions; 4) targeted oral health education, screening and sealant program.

DC Consumer and Regulations Authority
Lead Program partnered with DC Consumer and Regulatory Affairs to establish a home based lead assessment and mitigation program to decrease lead exposure in District residences.//2009//

/ 2010/ Within CHA, the coordination efforts continue among CHA's six sister Administrations as well as DCPS, DDOE and Dept of Health Care Financing (DHCF) to ensure that screening and identification of at-risk families and to increase enrollment in prenatal care and home visitation programs. Healthy Start's nurse case managers and family support workers link high-risk women to needed care provided by sister administratiions and agencies, including tobacco cessation, mental health and substance abuse treatment, HIV screening and care, lead testing and environmental assessment and other services.

Community Coordination Efforts -

In 2008 National Capitol Asthma Coalition closed its doors. In 2009 DC Control Asthma Now funded the American Lung Association to develop the DC Asthma Partnership, a new District collaboration.

CSHCN Advisory Board - The mission of the Children with Special Health Care Needs Advisory Board (the Board) is to: Provide advice and recommendations from a community based perspective to CHA on planning and implementing services to children with special health care needs in order to ensure that the CHA will: Provide and promote family centered, community based, coordinated care for children with special health care needs. Promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. Mary Frances Kornak currently cochairs the CHA/DOH Communications Committee.

The Board's goals include:
1. REPRESENT AND INTERPRET COMMUNITY NEEDS AND EXPECTATIONS
Communicate effectively with the community, ensuring that information about community needs, desires and satisfaction are promptly and thoroughly communicated to the CHA.
Share accurately and in a timely manner CHA's initiatives, plans and services to the community.

2. BE ENGAGED PROACTIVELY WITH THE COMMUNITY HEALTH ADMINISTRATION
Communicate regularly and clearly with CHA, providing advice and recommendations as requested. Ensure that mechanisms are in place for CHA's staff and leadership to respond promptly to the Board's recommendations and requests for information.

Obesity Interagency Work Group
CASH Bureau continues its efforts to address obesity among the District's school age children. The Obesity Interagency Work Group continues to meet and is active in developing the Strategic Plan to Address Obesity in the District.

HIVAAIDS Administration (HAA)
Continue to work with HIVAAIDS Administration (HAA) to conduct sexually transmitted disease screening in several DCPS high schools and expanded to all high schools in 2009. HIV or AIDS incidence highlights the need for an aggressive testing and outreach. HAA expanded its teen testing efforts with CBOs.

Continue collaborations with Addiction Prevention Recovery Administration (APRA), HIV-AIDS

Administration (HAA), Department of Mental Health (DMH), and Department of Human Services (DHS),

Other State Agency collaborations includes:

Department of Health Care Financing (DHCF)
CHA Bureaus continue to work closely with DHCF to identify opportunities to enroll women and children; improve the health of children and address the state priorities. Collaborative efforts include: asthma, medical homes, developmental screening. developmental screening and reporting of newborns lead blood level results and obesity in children projects and pre-conceptual counseling of teens.

Department of Corrections (DOC)
The PIHB collaborates with DOC to provide educational programs on parenting skills and safe sleep practicesfor their babies to women incarcerated in the DC Jail. DOH is also collaborating with juvenile justice programs to decrease youth violence.

Child and Family Services Agency (CFSA)
CFSA continues their bidirectional referrals of pregnant or parenting women that occurs between Perinatal and Infant Health Bureau. The Lead Program work with CFSA to conduct an environmental scan for lead in any home with foster children. When a child is placed with a family member there is counseling or controlling lead hazards.

The CASH Bureau coordinates with the CFSA to identify children with disabilities and developmental delays and assist with access to care. The Lead Program was instrumental in developing policies that require an environmental scan for lead in any home with foster children; the exception is, if a child is placed with a family member.

DC Public Schools (DCPS) and Office of the State Superintendent of Education (OSSE)
The CASH Bureau continues to work in concert with the DCPS and Charter Schools: 1) to provide oversight of the school nurse program; 2) health and sexual education classes; 3) health and sexuality education classes; and 4) targeted oral health education, screening and sealant program; 5) support return and expansion of physical education programs in all schools and 6) pregnancy prevention programs through improving self esteem through the "Girl Talk" and "Healthy Generations" programs.

DDOE Lead Program
DDOE Lead Program and DC Department of Housing and Community Development conduct home based lead assessment and mitigation program. The Lead Program will receive referrals related to lead testing on school questionnaire from the school nurses. The program will follow up on those children who are missing responses to lead testing questions.

Health Emergency Preparedness and Response Administration (HEPRA).
Collaborated with HEPRA regarding emergency preparedness for H1N1 flu and decisions related to school closures and child testing and treatment protocols. //2010//
An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

/2008/ The major priorities of the MPCA are to reduce infant mortality rates, enhance infant survival, enhance the MPCA's data gathering and analysis system, and improve its infrastructure. MPCA is focusing on developing programs that contribute to a lower infant mortality rate and enlarging public participation in the Title V program. MPCA also will work more closely with the District's community-based organizations to achieve these goals.

The ultimate goal of the Title V program will be to improve national and district performance measures. In addition, MPCA's realignment is expected to facilitate better communications and foster greater collaboration among Bureaus. This should have a positive impact on the Title V program. These are the factors that have influenced and will continue to influence the District's ability to maintain or improve the Health Systems Capacity Indicators.

The District's Title V program has the capacity to provide preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for CSHCN. Many of these program strategies already exist; others are being developed to meet the Health Systems Status Indicators. //2008//

/2009/ During this grant year DOH continued to focus on infant mortality; children with special health care needs; oral health; lead, asthma, youth injury/violence; administrative issues that improve program evaluation; data collection, analysis and integration. The Program staff are active participants in agency and community based coalitions focused on enhancement of maternal/child health issues. //2009//

/2010/ CHA continues to focus activities on the 2009 identified issues, awarding and monitoring subgrants to CBOs that are focused on the specific issue. //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	34.0	34.4	45.3	45.3	45.3
Numerator	119	121	161	161	161
Denominator	35029	35175	35513	35513	35513
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 Hospital Discharge Data is currently used until the 2007 dataset becomes available, then this measure will be updated. Discepancies in coding has caused the DC Hosital Association to retrieve the 2007 data set.

Notes - 2007
Data for 2007 willl be updated when made available. Disceepancies in data collection has caused the final dataset to be delayed. DC current is provided hospital dischage data by the DC Hospital Association.

Notes - 2006
This measure will be updated when the 2007 data becomes available.
Data includes all children less than 5, including those less than 1.

Narrative:
/2008/ MPCA received the data from the District of Columbia Hospitals Association and from the staff of the CDC-funded asthma control grant. The rate for children hospitalized for asthma in the District has been declining since 2001.

MPCA is one of the many governmental agencies that is represented on the DC CAN Intergovernmental Agency Committee as well as the Steering Committee and includes representation from private sector organizations. The purpose of the committee is to make recommendations to decrease asthma related morbidity and mortality.

One asthma control issue in which MPCA continues to be involved in is that of the development of a school-based policy on self-medication. The Child and Adolescent Health Bureau (CASH) staff continues to work with DC Public Schools to finalize and implement a policy specifying under what conditions students will be permitted to carry medications and self-medicate. //2008//

/2009/ DOH assigned a full time epidemiologist to the DC Control Asthma Now program to assist in data analysis and identification of strategies to improve management of children with asthma. The program will help to advance legislation allowing a child's permission to carry medications and self medicate during the school day by ensuring that school nurses train volunteer certified medication administration staff in DCPS/Chartered schools.

Under the Child Health Action Plan DOH expects to decrease Emergency Department visits for children by 20% by 2010; implement a quality improvement initiative for health care providers to ensure consistent high quality care for children with asthma, including an asthma registry and standardized asthma action plans and treatment records. //2009//

/2010/ Discepancies in coding has caused the DC Hosital Association to retrieve the 2007 data set. The data has not been updated and the previous years data is being reported.

DOH produced the "Burden of Asthma in the District of Columbia 2009" a comprehensive review of asthma as it affects all populations. Those subgroups that are disproportionately affected, include non Hispanic black populations: very young children aged 0-4 years; adolescent females, obese and overweight populations, residents with less than or some high school education and households with incomes less than $15,000 appear to be most affected. The document describes The DC Control Asthma Now program established in 2001 with a mission to improve the quality of life for residents who suffer from asthma.

The District continues to strive to decrease the hospital and emergency room admissions of children with asthma under 5 years of age through provider and parent education as well as mitigation strategies of environmental issues, such as smoking and dust to decrease exposure.

The report offers several recommendations: 1) maintain a consistent data collection mechanism that will capture prevalence, emergency department and hospitalization data by race, ward and school district level as well as asthma management by subpopulations; 2) develop improved data collection methodology for work related asthma; 3) asthma intervention programs to encourage proper asthma management by mitigating primary care barriers for at risk populations and continue its partnerships with DCPS; 4) integrate the risk factors of obesity and tobacco smoke in asthma prevention strategies, especially those targeting children; and 5) address the racial and socioeconomic disparities in asthma morbidity and mortality.

School children with asthma are permitted to self medicate during the school day and are required to have a treatment plan on file for review of teachers and others involved in their education or treatment. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	75.7	81.7	72.6	82.4	96.9
Numerator	3828	4334	4114	4143	5964
Denominator	5059	5303	5668	5026	6155
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data taken from the Medicaid 416 report.

There has been a steady increase in the percent of Medicaid enrolees who received one initial period screen.

Numerator taken from Row 8: Total eligible who should receive at least one initial or periodic screen for children <1.

Denominator taken from Row 9: total eligible receiving at least one initial or periodic screening for children <1.

Notes - 2007
Data taken from national Form 426: Annual EPSDT Participation Report.

Numerator taken from Row 8: Total eligible who should receive at least one initial or periodic screen for children <1.

Denominator taken from Row 9: total eligible receiving at least one initial or periodic screening for children <1.

Barriers to achieve the objective will be addresed in the new partnership between DC Partnership to Improve Health care quality and MAA to create an EPSDT well child registry.

Notes - 2006
Source: District of Columbia Form 416 FY06 Annual EPSDT Participation Report provided by the Medical Assistance Administration. This includes SCHIP recipients as well.

Narrative:
/2008/ There has been a steady increase in the percentage of Medicaid enrollees less than one year old who received at least one initial periodic screen, from 56.4 percent in 2002 to 72.6 percent in 2005. Unfortunately, there was a decline from 2005 to 2006. The increase can be attributed to the efforts of DC DOH and its partners, especially Managed Care Organizations that promote well-child visits. Reasons for the decline are not evident from the available data. However, MPCA staff will further explore this decline with the staff of the Medicaid Assistance Administration once 2007 data are available. //2008//

/2009/ The percentage of Medicaid enrollees less than one year old who received at least one initial periodic screen increased from 72.6% to 82.4%. The Medical Assistance Administration and the Perinatal and Infant Health Bureau actively promote newborn visits within the first 48 hours as well, outreach efforts encourage mothers to utilize primary care services. //2009//

/2010/ There has been a steady increase in the percentage of Medicaid enrollees less than

one year old who received at least one initial periodic screen, from 75.6 % in 2004 to 96.9 percent in 2008. DOH has sustained efforts to promote well-child visits in its various programs.

//2010//.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2008
There continues to be no change in separating the report of SCHIP data from EPSDT data. Medicaid and the District SCHIP are part of the same state program, and the Department of Health Care Financing (DHCF) does not publish separate data about SCHIP. Consequently, no data is available.

Notes - 2007
In the past conditions have been less than optimal in acquiring the data, but plans are underway working with our SSDI coordinator to get the information required for future grant applications.

Notes - 2006
The State has no breakout of SCHIP data within it's EPSDT data.

Narrative:
/2008/ SCHIP data is not reported separately from EPSDT data.

Medicaid and the District SCHIP are part of the same state program, and the Medical Assistance Administration does not publish numbers about SCHIP. Consequently, no data is available. //2008//

/2009/ There has been no change in separating the report of SCHIP data from EPSDT data. Medicaid and the District SCHIP are part of the same state program, and the Medical Assistance Administration does not publish separate data about SCHIP. Consequently, no data is available. //2009//

/2010/ There continues to be no change in separating the report of SCHIP data from EPSDT data. Medicaid and the District SCHIP are part of the same state program, and the Department of Health Care Financing (DHCF) does not publish separate data about SCHIP. Consequently, no data is available. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	60.9	56.4	55.9	71.4	71.4
Numerator	3779	4449	4727	4923	4923
Denominator	6210	7891	8461	6894	6894
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Notes - 2006
Data will be updated when final 2006 file becomes available.

Narrative:
/2008/ The percentage of women with a live birth during the reporting year who had prenatal visits was consistent from 2002 to 2004 and then increased approximately 10 percent in 2005. In the past two decades, there has been a national decline in prenatal care by family physicians and general practitioners. These changes can be explained by increases in non-physician providers, changes in the specialist workforce, or poor access to prenatal services. //2008//

/2009/ The relative consistency in the percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index is a reflection of the active outreach of the Perinatal and Infant Health Bureau's MOM van; Healthy Start case management and family support worker program as well as efforts of the Primary Care Association's medical home initiatives.

Based on a service gap analysis, DOH identified potential holes in the safety net of services for residents of the District and established three strategies for improvement in perinatal and infant care over the course of the next year. The first was increasing capacity and impact of the DOH home visitation program for pregnancy women. The federally funded Healthy Start programs constitute the city's primary initiative serving low-income expectant mothers and infants at risk for adverse perinatal health outcomes. These home visitation programs administered by DOH and by Mary's Center for Maternal and Child Care, Inc. promote a healthier physical and social environment in the home and link families to needed care. In 2008, additional funds will be used to expand the capacity of the Healthy Start program, including an investment to recruit and train family support workers who will team up with nurse case managers to address major risk factors affecting the health of pregnant and parenting women and their children. The Bureau hired and is training Family Support Workers through Healthy Start funding. These workers will provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and children. The first goal also includes a public information campaign to

educate women and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy and distribution of 15,000-18,000 cribs over the next seven years to prevent Sudden Infant Death Syndrome (SIDS). This program is funded through a grant from the Bill and Melinda Gates Foundation to First Candle.//2009//

/2010/ CHA expanded it Family Support Workers (FSWs) program. DOH has five FSWs; three are employees and two employed by contractors; Care First provides two additional FSWs for Ward 8. The Healthy Babies contracted for 6 family support workers. The program has now expanded from 200 visits in 2008 to 600 in December 2008. It continues to expand. With increase in case management services home visitation rates have increased (75% of all home visits are successful). The PIHB also provides educational services in 14 Department of Human Services Income Maintenance Administration sites. It continues its focus on increased early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

PIHB launched a Public Information Campaign -- "I am a Healthy DC Mom". The campaign themes include: 1) I will stay fit and eat right, 2) I will commit to 40 weeks, and 3) I will keep my baby safe and healthy. Posters appear on the inside/outside of buses. Topics include a bed sharin, pregnancy assistance kit, a consumer brochure.

PIBH collaborated with DHCF to enroll pregnant teens and women into Medicaid as well as collaborating with school nurses to identify pregnant teens in the first trimester. Community forum peer counselor participants suggested that screening and testing opportunities for young women include avenues that are after school events or fairs as well as develop outreach programs for girls out of school due to behavioral issues. The Bureau will also focus on prevention of rapid second pregnancies through its "Girl Talk" and Healthy Generations" programs.

The District has funded approxiimately $1M to improve perinatal outcomes. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	72.6	58.9	55.8	57.3	53.0
Numerator	65357	54062	53636	52259	52259
Denominator	89993	91734	96063	91236	98550
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Information taken from the Medicaid Form CMS-416: Annual EPSDT Participation Report.

The number of Medicaid eligible children who received a Medicaid paid service has decreased from 72.6% in 2004 to 57.3% in 2007 to 53% in 2008.

Numerator taken from Row 9. Total Eligibles Receiving at least one initial or periodic screen.
Denominator taken from Row 1: Total individuals eligible for EPSDT.

Notes - 2007
Data obtained from the Form 416:Annual EPSDT Participation Report provided by our Medicaid program for FY2007.

Denominator is line 1: total individuals eligible for EPSDT, while the numerator is line 9: Total eligible receiving at least one initial or periodic screen.

Narrative:
/2008/ From 2002 through 2006, the percentage of Medicaid-eligible children who received a service paid by Medicaid declined from 84.1 percent to 55.8 percent. However, this is an estimate and the District currently does not have reliable data on the number of potential Medicaid-eligible children. Some of these children may be covered outside the Medicaid program by an alliance of commercial insurers. It is estimated that between 10-12% of potential children in the District are eligible for Medicaid. Currently, the Medical Assistance Administration is examining the number of additional children who might be eligible. //2008//

/2009/ Data related to services received and paid by the Medicaid program is obtained from the Form 416:Annual EPSDT Participation Report provided by the DC Medicaid program for FY 2007. A slight increase is noted from 2006 to 2007. This is an estimated number because the District currently does not have reliable data on the number of potential Medicaid-eligible children. Some of these children may be covered outside the Medicaid program by the Alliance program or commercial insurers. It is estimated that between 10-12% of children in the District are potentially eligible for Medicaid but not enrolled. //2009//

/2010/
The data related to services received and paid by the Medicaid program is obtained from the Medicaid Form 416. The number of Medicaid eligible children who received a Medicaid paid service has has decreased from 72.6% in 2004 to 57.3% in 2007 to 53% in 2008. This is still an estimated number because the District does not have a reliable data system to reflect the number of potential Medicaid-eligible children. Some of these children may be covered outside the Medicaid. The estimate that 10-12% of children in the District are eligible for Medicaid but are not enrolled remains unchanged. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	36.2	40.3	36.0	42.5	47.3
Numerator	6533	7103	6523	7119	8533
Denominator	18045	17628	18125	16769	18025
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data taken from the 2008 Medicaid 416 Annual Report.

The percent of EPSDT eligible children increased from 36% in 2006 to 47.3% in 2008.

Numerator is taken from row 12A (Age Group 6-9), while the

Denominator is taken from Row 1 (Ages 6-9): Total individuals eligible for EPSDT (Age group 6-9).

Notes - 2007
Data obtained from the Form 416:Annual EPSDT Participation Report provided by our Medicaid program for FY2007.

Numerator is taken from row 12A (Age Group 6-9), while the denominator is taken from Row 1 Total individuals eligible for EPSDT (Age group 6-9).

Notes - 2006
Source: District of Columbia Form 416 FY06 Annual EPSDT Participation Report provided by the Medical Assistance Administration.

Narrative:
/2008/ The percentage of EPSDT-eligible children ages 6 through 9 who received dental services during the year increased from 2002 to 2005 and then declined in 2006. In 2006, the percent of EPSDT-eligible children ages 6 through 9 who have received any dental service during the year dropped to 36 %, a decline of 4% when compared with 2005, but matching the rate obtained in 2004.

MPCA recognizes that the provision of oral health services is a challenging problem in the District. Currently, the Oral Health Division's School Based Dental Program provides preventative dental services to DC Public Schools elementary school students who present their signed parental consent forms.

The Medical Assistance Administration does not receive school-based data. There may be more children receiving dental services than the statistics indicate. In other words, the number of children receiving dental services may be underreported.

The MPCA awarded a grant of $125,000 to SO Others Might Eat (SOME) and $100,000.00 to Howard University College of Dentistry to treat and improve the oral health of vulnerable District residents. SOME will also provide clinical cultural competency training for senior dental and senior dental hygiene students.

The DC Healthy Start MOM unit began providing basic dental services in May 2007. Perhaps these programs will result in an increasing percentage in succeeding years. //2008//

/2009/ The increase in the percentage of EPSDT-eligible children ages 6 through 9 who received dental services during the year from 36.0 to 47.3 in 2008, the percent increase may be due to several factors: 1) increase in dental reimbursement rates; 2) oral health data is collected on Form 416.

Two major efforts for the upcoming year include a memorandum of understanding between DOH and DCPS/OSSE to expand scope of work of dentists in DC public school sites and Charter schools.

The Child Health Plan targets by 2010 that 55% of all children 0-21 will have at least one oral health visit (for any reason) documented and to increase the rate of children aged 8 years old who have protective sealants on at least one of their permanent molar teeth by 5%.

CHA is in the process of developing another initiative to permit primary care providers to apply fluoride varnish to children and document on the Form 416. //2009//

/2010/

The Oral Health Division was able to successfully expand the School Based Dental Program by hiring an additional dentist and a community oral health educator (who also provides dental assistance to the additional dentist). As a result, DC Head Start centers and DC Public Schools (DCPS) elementary school students of all grades who presented their signed parental consent forms were provided with preventive oral health services. Schools with at least 50% of its student population enrolled in the National Free or Reduced Lunch Program are targeted by the Program. Dental services are provided in two schools simultaneously.

Nine hundred and sixty- three (963) DCPS students were examined in FY07 which represents a 123% increase from FY 06. Of those 963 students, 398 students -- or 64% -- received dental sealants. All students within DCPS elementary schools served, regardless of whether or not they presented their parental consent form, received oral health education.

In April 2009 the Medicaid reimbursement rates for medical and dental providers was increased to 100% of Medicare rates. This increase is expected to expand the number of dental providers willing to care for residents with Medicaid benefits. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	NaN	99.1	99.1
Numerator	0	0	0	4892	4892
Denominator	3420	3420	0	4938	4938
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Data used here is from 2007. When 2008 data becomes available this measure will be updated.

The District no longer has a clinical program for CSHCN rehab services. However, for 2007 provisional data was obtained from the District of Columbia's Healthcare Finance Agency. Data is

provisional.

The numerator reflects the number of unduplicated SSI beneficiaries who received services. The denominator reflects the number of SSI beneficiaries less than 16 years old in the District. Provisional data supplied by the District's Healthcare Finance Agency

Notes - 2007
The District no longer has a clinical program for CSHCN rehab services. However, for 2007 provisional data was obtained from the District of Columbia's Healthcare Finance Agency. Data is provisional.

The numerator reflects the number of unduplicated SSI beneficiaries who received services. The denominator reflects the number of SSI beneficiaries less than 16 years old in the District. Provisional data supplied by the District's Healthcare Finance Agency

Notes - 2006
The District no longer has a clinical program for CSHCN rehab services. Zero was entered in all fields.

Narrative:
/2008/ The District no longer maintains a rehabilitative services program for CSHCN. //2008//

/2009/ Although the District no longer has a clinical program for beneficiaries less than 16 years old receiving rehabilitative services it is considering a Medicaid requirement for billing to allow multidisciplinary providers to serve children with SHCNs. //2009//

/2010/ DOH is working with the Department of Health Care Financing (DHCF) to support same day billing by multidisciplinary providers that service children with SHCNs. DOH has not provided rehabilitation services to

Children wtih Special Needs for the past three years, do to the fact that a rehabilitation program was never in existence. With the restructing of the CSHCN division functions and the development of a Parent Information Network it has been made apparent that DOH needs to ensure that rehabilitation services are communicated to youth with special needs. While the DHCF become a cabinet level program and no longer is part of DOH, collaborations with the CSHCN office will be renewed in the coming year. //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	13.3	8.1	11.2

Notes - 2010
Information taken from a 2007 Birth-Medicaid linked file.
The percent of low birth weight in 2006 was the same in 2007 (11.2%).
There was a slightly lower Medicaid percentage in 2006 (13%) and a slightly higher non-medicaid percentage in 2006 (10.3%).

Narrative:
/2008/ Comparing the health system capacity indicators of Medicaid, non-Medicaid, and all MCH populations in the District was one of the principal objectives of the SSDI grant. MPCA staff is working closely with the Center for Policy, Planning, and Epidemiology to refine the data. Although the national upswing in multiple births has had an important influence on recent trends in pre-term birth rates, shorter gestations have also risen among singleton deliveries. Reasons for lower rates in the District are less clear since infant mortality has increased slightly, while low birth weight rates decreased in 2005. However, disparities exist when examining pre-term birth by race. African Americans have somewhat higher rates (14.9%) than white non-Hispanics (9.0%) and Hispanics (10.1%). See National Performance Measure 17. //2008//

/2009/ In an initiative under the Infant Mortality Plan, the Perinatal and Infant Health Bureau will design and implement a public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy in efforts to decrease infant morbidity and mortality due to low birth weights.

/2010/ The percent of low birth weight in 2006 was the same in 2007 (11.2%).
There was a slightly lower Medicaid percentage in 2006 (13%) and a slightly higher non-medicaid percentage in 2006 (10.3%).
The Perinatal and Infant Health Bureau designed and implemented its public information campaign called "I am a Healthy DC Mom". The themes include "I will stay fit and eat right", "I will commit to 40 Weeks" and "I will keep my baby safe and healthy". The campaign includes a public information component, a bed sharing campaign and distribution of pregnancy assistance kits. The campaign was launched in May 2009. It is expected there will be some change after a year of implementation. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	16.4	5.1	11.9

Notes - 2010
The infant death file for 2007 has 116 children. Because linked data is being used to make comparisons of the two groups, only children in the Infant death file that could be linked with the birth-Medicaid linked file are included. (Excluded were newborns born in 2006 or born in another state and not original residents.) Because of this approach, a cohort infant mortality rate is calculated, giving an overall result that is lower (11.9 per 1,000) than the rate calculated by the traditional methods (13.1 per 1,000).

For the Medicaid group 88 deaths/5,366 Medicaid births as compared to the Non-Medicaid group of 18 deaths/3,506 births. Overall, 106 deaths/8,872 births resulted in a 11.9 rate per 1,000 births.
This was slightly higher than 2006, when the rate was 11.3%

Narrative:

/2008/ The District has a high infant mortality rate in comparison to the rest of the country. Factors that account for more than half of the District's infant deaths include maternal complications of pregnancy, birth defects, complications of delivery, and disorders related to short gestation and low birth weight. Other factors associated with infant mortality are adequacy of prenatal care, reproductive tract infections, race, age, and ward of residence of the mother. Socioeconomic disadvantage, poverty and lack of health insurance are among obstacles to health and health care often cited. Many of the conditions and risk factors associated with maternal and infant mortality in the District of Columbia disproportionately affect women of color.

In 2008, a major priority of MPCA is to fund sub-grants to reduce infant mortality in the District. A new data chief and CDC epidemiologist have joined the MPCA. They will focus on evaluation, surveillance systems, and infant mortality by using Periodic Periods of Risk (PPOR) and rebuilding PRAMS. MPCA also plans to revitalize the Birth Defects program in order to capture, track and link families of children with birth defects to services. Identifying these children will support efforts of MPCA to reduce infant mortality and morbidity in the District.

MPCA will continue participating in the District-wide Infant Mortality Advisory Committee. The combination of the above-mentioned activities is intended to help reduce the number of infant deaths. //2008//

/2009/ The Infant Mortality Plan strategies include: recruit, train and deploy family support workers under the Healthy Start program to provide complementary support services that address psychological and medical risk factors affecting pregnant and parenting women and their children.

Facilitate the distribution of 15,000 to 18,000 free cribs over the next seven years to low-income mothers to prevent Sudden Infant Death Syndrome (SIDS), thanks to an $11 million grant from the Bill & Melinda Gates Foundation to First Candle. //2009//

/2010/
Traditional methods for calculating the infant death rate used by the DC State Center for Health Statistics (rate of 13.1 per 1,000) is a larger death rate than that produced by by the HSRA definition used in this indicator (rate of 11.9 per 1,000). The 2007 Medicaid/Non Medicaid value of 11.9% was higher than the 2006 rate of 11.3% per 1,000.

The Safe Crib Program continues to distribute free cribs to eligible District residents. In 2008, the program distributed over 500 cribs. The program is awaiting the delivery of free cribs for First Candle who was awarded an $11 million grant from the Bill and Melinda Gates Foundation. The cribs have been delayed because of crib development issues. It is expected that these cribs will be distributed this year. Perinatal and Infant Health Bureau also plans an evaluation of the Healthy Start program to determine the effectiveness of the program and identify opportunities for improvement.

In 2010 CHA plans to reestablish the PRAMS survey in order to identify factors that impact infant mortality. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity*	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	63.8	85	73

Notes - 2010
Information taken from a 2007 Birth-Medicaid linked file.

In 2006 the population percentage of babies born to women receiving PNC in the first trimester was 75%. This was slightly lower in 2007 (73%).
The percentage among the Medcaid population was lower in 2007 than 2006 and the percentage in the non medicaid population was higher in 2007 than 2006.

Narrative:
/2008/ The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester is much lower in Medicaid than in the non-Medicaid population. DC Healthy Start staff will continue identifying and recruiting pregnant women early and enroll them into prenatal care. Staff will continue to provide initial prenatal care visits on the MOM unit to pregnant women not yet enrolled in care. The capacity to provide case management services to high-risk pregnant women will be maintained in the coming year. The 1-800-MOM-BABY HEALTHLINE telephone number will continue to provide advice and information for pregnant women. The MPCA intends to use these programs to reach more pregnant women on Medicaid. See National Performance Measure 18. //2008//

/2009/ The percentage of pregnant women receiving Medicaid benefits entering the first trimester of pregnancy continues to be considerably lower than non Medicaid pregnant women. The Perinatal and Infant Health Bureau staff is aggressively continuing its outreach efforts through the Healthy Start, family support worker program and MOM unit program; enrolling women in prenatal care and in Medicaid programs, as needed. //2009//

/2010/
In 2006 the population percentage of babies born to women receiving PNC in the first trimester was 75%. This was slightly lower in 2007 (73%).

Pregnant women entering care in the first trimester of pregnancy and receiving Medicaid benefits continue to lag behind non Medicaid pregnant women. The percentage among the Medcaid population was lower in 2007 than 2006 and the percentage in the non medicaid population was higher in 2007 than 2006.

The Perinatal and Infant Health Bureau has increased its outreach efforts to include schools, DC Jail, and shelters, as well as added family support workers and launched a public campaign. It also plans on evaluating the Healthy Start Program. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
Comparison of health system capacity indicators for Medicaid,			**MEDICAID**	**NON-MEDICAID**	**ALL**

non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	60.6	80.2	71.4

Notes - 2010
Information taken from a 2007 Birth-Medicaid linked file.
In 2006 the total percent was 55.9%. This increased to 73% in 2007.
There was an increase in both medicaid and non medicaid percents.

Narrative:
/2008/ The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester is much lower in Medicaid than in the non-Medicaid population.

DC Healthy Start I and II staff will continue identifying and recruiting pregnant women early and enroll them into prenatal care and will continue to provide initial prenatal care visits on the MOM unit to pregnant women not yet enrolled in care. The capacity to provide case management services to high-risk pregnant women will be maintained in the coming year and the 1-800-MOM-BABY HEALTHLINE telephone number will continue to provide advice and information for pregnant women. The MPCA will use these programs to reach more pregnant women on Medicaid. See National Performance Measure 18. //2008//

/2009/ The data presented for 2006 reflects the disparities between Medicaid and non medicaid pregnant women with adequate prenatal care. Strategies to address this disparaties include increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance and facilitate outreach and linkages to care for homeless pregnant women. The Bureau has implemented a collaborative project with the Department of Corrections to identify pregnant women in the criminal justice system.//2009//

/2010/
In 2006 the total percent of women with adequate prenatal care was 55.9%. This increased to 73% in 2007.
There was also an increase in both medicaid and non medicaid percents.

The data presented for 2007 continues to reflect though the disparities between the Medicaid and non Medicaid pregnant women with adequate prenatal care. Strategies in place to address the disparities include increased early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance through collaboration with DCPS, DC Jail, community based organizations as well as shelters. The Bureau expanded the family support worker program and launched a public awareness campaign aimed at pregnant women and their children. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

Infants (0 to 1)	2008	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	300

Narrative:
/2008/ Eligibility for Medicaid-SCHIP for children 18 years or younger increased from 200 percent to 300 percent of the federal poverty level as of June 1, 2007. //2008//

/2009// the Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300% of the Federal Poverty Level. //2009//

/2010/ the Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300% of the Federal Poverty Level. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 300 300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 300 300

Narrative:
/2008/ As of June 1, 2007, eligibility for Medicaid-SCHIP for children 18 years or younger increased from 200 percent to 300 percent of the federal poverty level. //2008//

/2009/ /Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300% of the Federal Poverty Level. //2009//

/2010/ /Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300% of the Federal Poverty Level. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	300

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2008	300

Narrative:
/2008/ As of June 1, 2007, eligibility for Medicaid-SCHIP for children 18 years or younger increased from 200 percent to 300 percent of the federal poverty level. Eligibility included pregnant women. //2008//

/2009/ Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300 percent of the Federal Poverty Level. Eligibility included pregnant women. //2009//

/2010/ Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300 percent of the Federal Poverty Level. Eligibility included pregnant women. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2010

Narrative:
In 2006 the MCH program began linking data for the Title V submission, through SSDI funding. In 2007 newborn screening data (metabolic screening and newborn hearing) data was linked with the most recent birth file. In addition, a Medicaid file of newborns was linked with the birth file. In the previous two cycles the MCH program has used SQL code to match and link files using MS ACCESS. During the year program staff began experimenting with "Link Plus", a CDC-funded probability statistical linking software designed to work with cancer data. (Dan)

/2008/ Until recently, MPCA had limited access to electronic databases and had to formally request the data from the appropriate agency. Staff will be attending CDC/HRSA Maternal and Child Health epidemiology training in New Mexico to enhance skill sets in data trend analysis, needs assessment, and program evaluation. Moreover, MPCA was accepted into the CityMatch Data Institute to obtain technical assistance for both data analysis and program evaluation on our Safe Start Crib Program to address sudden infant death syndrome and infant mortality within the District.

In 2006, the MCH program began linking data for the Title V submission, through SSDI funding. In 2007, newborn screening data (metabolic screening and newborn hearing) data was linked with the most recent birth file. In addition, a Medicaid file of newborns was linked with the birth file. In the previous two cycles, the MCH program has used SQL code to match and link files using MS ACCESS. During the year, program staff began experimenting with "Link Plus," a CDC-funded probability statistical linking software designed to work with cancer data.

Dr. Genet Burka and Stephanie Alexander will be conducting a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. They will be collaborating with a number of programs to assess the various data that are captured for inclusion in trend analysis. In addition, they will be developing a database on infant birth, morbidity and mortality statistics for the District to assist programs with planning and services. //2008//

/2009/ CHA proposes a pilot PRAMS-like survey in 2009. A request for proposal and scope of work will be developed and vendor solicited to provide the survey.

Dr. Genet Burka continues to lead a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. The process includes collaboration with a number of programs to assess the various data that are captured for inclusion in trend analysis and developing a database on infant birth, morbidity and mortality statistics for the District to assist programs with planning and services. The database will be a component of the Data Integration project. //2009//

/2010/ CHA plans to implement a PRAMS survey in 2010 rather than a pilot project. The additional data collected through the PRAMS survey will facilitate identification and effect of current and future programs. In addition, Perinatal and Infant Health Bureau plans to conduct an evaluation of its Healthy Start Program to identify gaps and opportunities for improvement. The Title V Needs Assessment project will begin this summer. The results of the Needs Assessment will further assist CHA in defining strategies to address the needs of those served through the Title V grant. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
/2008/ Since 1999, the reported use of tobacco has declined among male and female students. Out-of-school youth were not surveyed. See State Performance Measure 4. //2008//

/2009/ The Child Health Action Plan focuses on reducing youth tobacco product use by 10% by 2010. The strategies include conducting a minimum of 450 tobacco sales compliance inspections to reduce youth access to tobacco per year. The YRBS data is available through the collaboration with DC Public Schools. //2009//

/2010/ Cigarette smoking rates among American teens in 2008 are at the lowest levels since at least as far back as the early 1990s., according to the Monitoring the Future (MTF) study based at the University of Michigan, which has been surveying national samples of 8th-, 10th-, and 12th-grade students each year since 1991. MTF tracks tobacco use with surveys administered to a national sample of over 45,000 students in about 400 secondary schools each year. This year represents the low point for smoking in all three grades. The proportions of students indicating any smoking in the prior 30 days (called "monthly prevalence") stands at 7 percent, 12 percent, and 20 percent in grades 8, 10, and 12, respectively.

These rates reflect large declines since the recent peaks in the mid-1990s: 8th graders' smoking rates are down by two thirds, 10th graders' by more than half, and 12th graders' by nearly half. "I can't begin to tell you what a dramatic difference this is going to make in the health and longevity of this generation," said Lloyd Johnston, the study's principal investigator. "The fact that teen smoking is still declining is particularly encouraging, because a couple of years ago it looked like the long decline in youth smoking might be coming to an end." The District continues its efforts to stop initiations of youth smoking as well as increasing efforts to stop smoking. DOH released a new music video "Nasty" about the many reasons not to use tobacco. The video, created as a teaching tool for teenagers, and includes students from Anacostia Senior High School was put together through a partnership with the DC Tobacco Free Families (DCTFF) Campaign, a coalition including DOH, the American Lung Association of DC and the American Cancer Society. DOH funds DCTFF with the District's tobacco settlement funds. Through the efforts of the students at Anacostia Senior High School and other partners DOH has a new tool in its campaign to educate youth about the dangers of tobacco use. Dr. Pierre Vigilence, Director of DOH states that "The video and song are an entertaining but an honest portrayal of the toll smoking can take on someone physically and socially."

The video is part of DCTFF's goals to reduce tobacco use among DC's youth by developing strategies and programming with DC youth on tobacco-free messaging, including training youth ambassadors and peer leaders to conduct outreach on the dangers of tobacco addiction.

Steve Fitzhugh, who wrote and performed the song in the video, worked with students at Anacostia High School and Cerebral Lounge, the production company, to come up with the concept and film the video in the Anacostia neighborhood. Members from The House, a youth center in Anacostia, coached, auditioned and provided guidance for the Anacostia Students in the video. The House headquarters also served as a film site.
The video will be used in educational settings and comes with a facilitator's guide to help

teachers and peer leaders lead discussions about the themes and messages of "Nasty". Through the video and discussions, DOH hopes to educate youth about tobacco companies' strategies to target teenagers and about the consequences of tobacco use.

Other DC efforts to curb selling cigarettes to minors include unannounced visits to community corner stores to cite owners for selling cigarettes to minors. This is a labor intensive effort and, although effective, it is difficult to monitor and visit all corner stores.

CHA will also implement a full PRAMS Survey in 2010 which will include questions related to smoking. Of importance to note is that the District has the lowest self reported rate of smoking during pregnancy. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

During this reporting period, MFHA continued to focus on the priorities delineated in June 2000, working within the Department of Health (DOH) in an environment that has undergone significant change over the past 5 years. The continuing restructuring of the District's safety net for the provision of health care for the poor, hospital closures and financial crises, the aftermath of September 11, 2001 with an increasing emphasis in public health on responding to potential bioterrorism, coupled with diminished tax revenues affected MFHA's resources and activities. Changes occurred within the DOH as well. Throughout the period 2000-2005, MFHA continued to focus on its 5-year objectives and long term priorities. Each year from 2000 to 2004 prior to the submission of the Title V block grant application, senior staff met to review and discuss annual performance measures. As a result, a few of the priorities were slightly modified, for example, changing "establish" to "institutionalize", but remained essentially the same.

In preparation for the July 2003 block grant report, application submission, and 5-year needs assessment, staff and consultants considered the findings from the MCHB-sponsored national survey of CSHCN. Reviewing the DC data in comparison to US data as well as information collected as a result of activity on categorical grants, targets for the performance measures specific to CSHCN were set.

In the spring of 2005 MFHA completed the collection of data for the 5-year needs assessment. As described in the needs assessment section of this application, the data collection and analysis staff compiled data from numerous sources to describe the District's maternal and child health populations. These data were presented to forums and focus groups, and the report was widely distributed. Several focus groups were convened to elicit input on residents' needs. The focus groups included groups dedicated to teens, parents and Latinas. On June 27, 2005, 9 staff members met in a 3-hour priority-setting exercise to discuss the needs assessment findings, both the trends outlined in the quantitative analysis and the comments from the focus groups, as well as their own experiences in administering programs. Also taken into account were the District's Healthy People 2010, an emerging state health plan to guide the certificate of need process, the state Medicaid plan, the developing state adolescent health plan, and planning for categorical grants.

The priority-setting exercise gave special attention to the issues that were unanimous across focus groups. Next, the staff reviewed the 2000 priorities and discussed whether any should be retained for the 2006-2010 period. It was generally agreed that considerable progress had been made toward 3 priorities; therefore, they were moved off the high priority list. It was noted that changing priorities did not mean work on these issues and programs would cease. A 4th priority, monitor the effects of welfare repeal on health status, had yet to receive much attention and now seemed beyond the scope of existing resources, and it too from removed from the priority list.

The staff then formulated 5 new priorities. In the next section of the application, the status of and plans for each of the priorities is described. First, the status of priorities set in June 2000 is described, including the 4 priorities that will not be continued into 2006-2010. Next, the status of 3 priorities established in 2000 and carried over into the 2006-2010 period is described. Then 5 new priorities are described. Priorities are numbered only for purposes of reference in discussion.

MFHA will continue to report on the same 7 state performance measures delineated in previous years due to their emphasis on issues of considerable importance to the District maternal and child population:

1 Increase the % of women who receive adequate prenatal care;
2 Increase EPSDT participation;
3 Reduce the prevalence of lead levels exceeding 10ug/dl among children through age 6;
4 Reduce the prevalence of tobacco use among pregnant women;

5 Reduce the proportion of births resulting from unintended pregnancies;
6 Reduce the percent of women that give birth with no prenatal care or prenatal care initiated in 3rd trimester; and
7 Reduce the incidence of repeat births for teens less than 19 years of age.

MFHA recognizes that the needs assessment is an ongoing process of reviewing new information and reassessing priorities. Toward that end, the Maternal and Child Health Officer is recommending to the director of the Department of Health that a Maternal and Child Health Work Group be convened to review the findings of the recently submitted needs assessment and discuss the implications for the development of policy in the District. The Work Group would be charged with developing a short-term plan for approaching and informing local policy makers on ways to improve the health of women, children and families.

The recommended composition of the Work Group will include maternal and child health services providers, including CSHCN, advocates, and representatives of government agencies.

/2007/ The recommendation was sent forward to the DOH director in August 2005. It was not acted upon. In October 2006 there was a transition in leadership to a new senior deputy director. See the section on public input for current plans for a maternal and child health advisory group.

Following the realignment of MFHA (see agency capacity) and the appointment of a new senior deputy director, the priority needs delineated in July 2005 were reviewed. During May through June 2006, senior staff reviewed the priority needs, taking into account changes in the environment, new directives, recently available data on health measures, resource requirements, and information obtained from participation in the technical assistance workshop presented in May 2006 by MCHB. Extensive discussions resulted in several changes to the priority needs list.

Two state performance measures are being replaced with new measures. These changes are discussed in the next section of this application. //2007//

/2008/ During the reporting period, the former Maternal and Family Health Administration and the Primary Care and Prevention Administration were realigned (see Organizational Structure) as the Maternal and Primary Care Administration (MPCA). MPCA established a Maternal and Child Health Services Title V Block Grant Planning Team that was co-chaired by Joyce Brooks and Paula S.F. Marshall. The team guided the development of the Title V Application for FY 2008 and the Annual Report for FY 2006. The Team reviewed the state priorities delineated in July 2006 taking into account the public input received from the MPCA advisory committees and community collaboratives, Healthy People 2010 objectives, DC DOH Strategic Business Plan, program goals, performance measures, program activities, and resources. //2008//

/2009/ The Community Health Administration (CHA) is responsible for the oversight and management of the Title V Block Grant including the issuance and award of community based grants to support state priorities; grantee monitoring and evaluation of compliance with performance measures; data collection and analysis; program and staff progress in accomplishment of program goals and objectives; and identification of coordination activities with sister Bureaus.

During the past year CHA continued to focus on the 10 State Priorities discussed in the previous sections. The activities are described in the Health Care Indicators sections of the application. Each Bureau actively identifies opportunities to improve maternal and child health disparities for District residents. Staff utilize coalitions comprised of inter and intragency representatives, providers, community based organizations and families to identify strategies to develop policies, expand resources, facilitate access to services and knowledge.//2009//

/2010/ CHA's responsibilities for the oversight and management of the Title V Block grant remain unchanged from the 2009 description. Its four Bureaus (PIBH, CASH and Nutrition

and Physical Fitness and Bureau of Cancer and Chronic Disease) focuses on activities to decrease health disparities through policy initiatives, subgrants to community based organizations; and intra and interagency collaborations; consumer advisory boards, etc. CHA encourages and recommends parent and advocate participation on subgrant awards.

With the availability of ARRA funds the District developed and convened 13 workgroups to plan, coordinate, and oversee activities related to ARRA funds. Examples: Education, Employment, Health Care, Housing, Human Services, Medicaid, Small Business, Transportation, etc. //2010//

An attachment is included in this section.

B. State Priorities

Direct HealthCare Services (DHS), Infrastructure Building (IB), population-based services (PBS), enabling services (ES)

Increase awareness of the role of mental health in adolescent risk behaviors, school achievement and perinatal outcomes; and increase availability of preventive services. (IB, PBS, ES)

Universal depression screening of Healthy Start clients will continue through June 2009. A 1-year grant to expand perinatal depression screening FY 2006. Work with the DC Department of Mental Health (DMH) add 2 FTE licensed therapist positions at the Parent and Infant Development Program to receive, assess, diagnose and treat Healthy Start clients who screen positive for depression or other mental health problems. MFHA will work with MCOs to incorporate more mental health services into physical care. This new priority is related to NP# 3, 5, 8, 16 and SP# 1, 5, 7.

/2008/ This priority is being discontinued. MPCA acknowledges that mental health is a major issue of concern for all populations in the District. Work with the DMH to launch its Teen-screen Initiative, a suicide screening and counseling program. The DC Healthy Start Project will continue to screen all pregnant and parenting women for depression throughout the duration of their participation in the program (up to child's second birthday). //2008//

Increase the proportion of the population that is insured, and increase the comprehensiveness of the coverage to include primary preventative services and preconceptional services. (ID, ES) MOUs were established with the 4 Medicaid MCOs to improve services to the maternal and child health populations, including more comprehensive and accessible preconception and interconception health care services.

/2007/ This priority is being revised to: Increase the proportion of the population that receives comprehensive primary preventative and preconceptional services. The restatement emphasizes utilization and receipt of services rather than availability. The District is increasing Medicaid-SCHIP eligibility from 200 to 300% of the FPL, Must inform the public of the change in eligibility and how to access and use services, particularly preventive services. //2007//

The Administration has continued to disseminate information about Medicaid-SCHIP and the Alliance. See NP# 4, 13, 14 and SP# 2.

/2008/ This priority has been discontinued. It will be addressed in our efforts to decrease infant mortality//2008//

1. Improve oral health among children, youth, and pregnant women. (IB, PBS, DHS)

Although Medicaid reimbursement rates were slightly adjusted in FY 2003, with another increase

in the proposed FY 2006 budget, and increasing recognition of the lack of accessible services has resulted in mobile dental services offered in a few underserved neighborhoods, efforts have yet to result in observable improvements in access to and utilization of oral health services. In September 2002 the Administration secured funds from the Office of the Assistant Secretary for Planning and Evaluation in the amount of $450,000 to implement a school-based oral health program that would restructure the manner in which oral health services are delivered to CSHCN enrolled in the public schools. Beginning with 2 schools dedicated to special needs children, the grant funds were applied in 2004 to renovate the medical/dental health suites and install telemedicine capabilities in order to serve the oral health needs of SHCN students. Children were digitally linked to dentists at CNMC who provided oral screenings, consultations, and referrals.

FY 2005, services were expanded to additional schools with large numbers of CSHCN among infrastructure deficiencies within the school system.

The Healthy Start MOM unit, which is expected to be functioning by the beginning of FY 2006, /2007/ now expected in FY 2007 //2007// will add oral health screening for pregnant and interconceptional women. In addition to increasing oral health infrastructure by establishing an oral health division, an Oral Health Coalition was formed of organizations representing oral health and dental services providers. See NP# 9 and SP# 2.

/2008/ The Oral Health Division's School Based Dental Program provides preventive dental services to DCPS elementary school students of all grades who present their signed parental consent forms. MPCA awarded sub grants of $125,000 to So Others Might Eat (SOME) and $100,000.00 to Howard University College of Dentistry to treat and improve the oral health of vulnerable District residents. The DC MOM Van provides basic dental services. //2008//

/2009/ Three oral health activities: the MOM van provides prenatal dental screening; MOU with DCPS and Chartered Schools to expand oral health services and screenings, fluoride treatment and sealants to children and oral health education programs. //2009//

/2010/ The Oral Health Division was able to successfully expand the School Based Dental Program (Program) by hiring an additional dentist and a community oral health educator. As a result, DC Head Start centers and DC Public Schools (DCPS) elementary school students who had a parental consent form were targeted for oral health services. Schools with at least 50% of its student population enrolled in the National Free or Reduced Lunch Program are targeted by the Program. This Program allows students enrolled in schools that meet this criteria with necessary dental services they would not otherwise have access to.//2010//

2. Reduce unintended pregnancies and teen births. (ES)

The Teen Mothers Take Charge (TMTC) program provided monies to 4 COB's to provide care coordination and enrichment services to teen mothers with the objective of preventing unintended repeat pregnancies and assisting young mothers to become self sufficient. In FY 2005, due to budgetary reductions, the TMTC program provided services to 75 clients at 1 community based organization. The program is expected to continue through FY 2006, with an expected client load of 95 young women.

In June 2005, the 2 Healthy Start projects were refunded for a 4-year period with a focus to include perinatal and interconceptional care case management. The case managers support the clients in avoiding unplanned repeat pregnancies within that time period. See also NP # 8, SP# 5, 7. This remains a priority for the period 2006-2010.

/2008/ The Health and Sexuality Education program provides comprehensive health and sexuality education to District youths, as well as providing training and technical assistance to community-based organizations. In FY 2006, a total of 16 elementary schools, 4 senior high

schools, 3 middle schools, 2 public charter schools, and 2 faith-based organizations received program services. A total of 1,231 youth received health and sexuality education, with the highest concentration of program services occurring in Wards 5, 6, 7 and 8. In addition, the Abstinence Education Program educates District youths about the benefits of sexual abstinence until marriage. During FY 2006 the program conducted over 100 abstinence education sessions throughout the District of Columbia. A total of 1,000 youth in 30 DC Public Schools received abstinence education sessions. //2008//

/2009/ CASH Bureau expanded its sexual health program utilizing the Carrera model in DCPS and Charter Schools. //2009//

/2010/ CHA continues Healthy Start and Family Support Worker programs with a focus to include perinatal and interconceptual case management. CASH continues health and sexuality education programs in DCPS. DCPS is considering implementation of health and sexuality education in all schools. CHA focusing on decreasing rapid second pregnancies through "Girl Talk" and "Healthy Generations". //2010//

3. Enhance nutrition and increase physical activity for children and youth. (ES)

In FY 2006, as WIC and related nutrition programs are integrated into MFHA, to better integrate programs, activities and objectives across bureaus as well as link databases.

MFHA will continue to participate in the Obesity Prevention Advisory Council, which was convened in June 2005 by the MAA.

The recently re-funded Healthy Start grant includes a component to enlist clients in a post partum nutrition and physical activity program, partnering with the WIC Eat Smart/Move More program to establish sites specifically for Healthy Start participants. /2007/ This idea was abandoned. //2007//

In 2005, a MFHA staff member's time was allocated to coordinate with a local radio station, WPFW, campaign to establish "Movement Clubs". WPFW promotes the program through the Web site (www.wpfw.org), on-air announcements and public affairs programs. MFHA will assess the results to determine how best to support and/or expand this effort in 2006.

/2007/ Funding is being sought for a reunion of movement clubs, in which 1,500 persons participated, and production of a DVD featuring physical movement to promote sustainability of physical activities is planned for completion in 2006. See other activities section of this application. //2007//

MFHA will also use its relationships with the public school system to understand and influence policies pertaining to vending machine access and contents, school and summer feeding programs, and school event sponsorships and fundraising. This priority may be somewhat related to NP# 11, SP# 1, O#6 and 09C.

/2008/ The Nutrition and Physical Fitness Bureau provides nutrition and fitness classes to school children, parents, and seniors using USDA's Team Nutrition curriculum. The Bureau has been an active participant with the Ward 8 Childhood Obesity Collaborative, working to support an initiative providing assistance and training to Family Day Care Providers, as well as a range of policy initiatives on expanding fresh food access in that area of the city, the poorest ward in the District. //2008//

/2009/ The Nutrition and Physical Fitness Bureau's collaborative efforts developed initiatives to shift eating behaviors to foods with nutritional dietary value; Food Stamp Education Plan and awarded a TEAM Nutrition grant; furthered the DCPS nutrition policy; increase the level of physical activity in schools and health fair promotions.

Legislation was passed to increase breast feeding friendly workplaces in DC. DOH continues to support is Lactation Center and Resource Room.

DC Obesity Work Group formed: obesity prevention and reduction, State Plan Development.//2009//

/2010/ The Nutrition and Fitness Bureau continues its efforts to expand breast feeding program; enhance the farmers' market program and utilization of food stamps to purchase fresh fruits and vegetables; as well as continue to promote the DCPS nutrition program.

DCPS require physical education in school and after school programs. All child development centers offer "I am Moving, I am Learning" program.

DCPS and OSSE implemented a new food vendor contract which improves the nutritional value of food served and offered to school children. //2010//

4. Decrease violence toward and by children and youth. (PBS)

Plans for FY 2006 include: establishment of a city-wide coalition for youth violence prevention that consists of government, community and faith-based organizations; partnering to develop a youth violence prevention initiative for DC; and briefing city officials on the Department's stance and objectives relative to youth violence prevention in the District. Staff will seek funding opportunities to operationalize these plans.

The proposed realignment of the DOH includes the transfer of a violence prevention program (primarily focusing on sexual assault) to MFHA, increasing the opportunities for a more integrated violence prevention intervention strategy. Staff will be assisted to exploit opportunities to coordinate and integrate violence prevention programs. Efforts around this priority are expected to affect NP# 6, 8, 10 and O# 1, 2, 6.

/2008/ The MPCA Rape Prevention and Education Program collaborates with public and private providers to address violence toward and by children and youth in the District and targets schools, universities, and community members. //2008//

/2009/ CHA plans to solicit strategies from organizations currently addressing violence toward and by children and youth. Public and private partnership developed a poster campaign that will be distributed to DC schools.

Technical Assistance was requested. //2009//

/2010/ Title V funds suppported Edgewood- Brookland Collaborative to address violence issues toward children and youth. In addition the Metropolitan Police Department (MPD) and Department of Youth Rehabilitation Services (DYRS) have submitted six applications to the US Department of Justice funding under the American Recovery and Reinvestment Act for a number of high-priority law enforcement and juvenile justice related projects that includes projects to work with court-involved community youth. //2010//

5. Increase access to medical homes for CSHCN and support seamless systems of care. (IB, DS)

/2007/ This priority is being restated to emphasize utilization rather than access and availability: Educate consumer and providers to increase utilization of medical homes.

Due to the Medicaid carve-out for SSI beneficiaries, changes in the Medicaid MCO contracts, and the expansion of Medicaid-SCHIP, District residents increasingly have opportunities for obtaining care within a Medicaid home. //2007//

MFHA staff will continue to work to ensure that CSHCN services are well-integrated with Medicaid-SCHIP services. In Fiscal Year 2006, staff will work with Medicaid-SCHIP contractors and providers to adopt evidence-based standards of care for CSHCN, and support the training of staff in selected clinics to expand diagnostic and treatment skills for genetic disorders.

A large-scale effort (Medical Homes DC) under the leadership of the DC Primary Care Association is underway to increase the supply and capacity of community-based clinics to provide medical homes. Advocates for CSHCN have yet to be involved in these efforts. During FY 2006, Administration staff will attempt to coordinate their plans with those of the primary care "system".

Staff will continue to support the CSHCN Advisory Council in the identification of needs and opportunities for strengthening referral systems across systems of care. This priority is related to NP# 3, 4, 5, 6 and SP#3.

/2008/ This priority has been reworded as above. MPCA staff will continue working to ensure that CSHCN services are well-integrated with Medicaid-SCHIP services. Staff will work with Medicaid-SCHIP contractors and providers to adopt evidence-based standards of care for CSHCN, and support the training of staff in selected
clinics to expand diagnostic and treatment skills for genetic disorders. //2008//

/2009/ CHA continues to work with DCPCA and MAA to ensure that children with SHCN are well integrated with Medicaid-SCHIP program. //2009//

/2010/ HRSA funded grant to CNMC to pilot a family navigation program to engage CSHCN families in medical homes. DCPCA continues its focus and mission to expand medical homes for District residents including children with special health care needs.//2010//

6. Improve MPCA capacities to collect, acquire, analyze and utilize program data and strengthen surveillance systems. (IB)

Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status.
The overarching priority delineated in 2000 will be carried over in the 2006-2010 period. This priority connects all 4 levels of services. Although a number of District health status measures show improvement, profound disparities continue to exist. Most of the national and District performance measures, in particular the outcome measures, are affected by disparities The Administration will continue to operate the grant-funded Healthy Start projects, which are designed to eliminate disparities in perinatal outcomes among African American women.

/2007/ This priority is being changed to reflect the need to strengthen MFHA surveillance systems: Manage surveillance to eliminate disparities. The urgent need to improve MFHA capacity to collect, acquire, analyze and use program data has been evidenced throughout this application. Few analytic efforts are underway to help to determine appropriate interventions. Making this an explicit priority is consistent with proposed SSDI grant activities.

/2008/The new data chief and CDC epidemiologist that joined the MPCA are focusing on evaluation, surveillance systems, and infant mortality by using PPOR and rebuilding PRAMS. Also, DC DOH will link the newborn file with WIC, CLPSEP, and Healthy Start. DC DOH received a $9.8 million Medicaid Transformation grant to improve health outcomes, and analyze Medicaid data with patients' medical histories. Client data will be shared on a data sharing hub relying on a central client index. //2008//

/2009/ CHA initiated the data integration project that will support the timely and quality collection

of disparate data across DOH administrations. Dr. Burka leads CHA's efforts focusing on evaluation, surveillance systems, and infant mortality tracking outcomes of Title V funded programs and not just a count of services. //2009//

/2010/ Due to information system problems the data integration project was canceled because of difficulties in accurate data matching/integration. /2010//

7. Provide STD screening and prevention services for adolescents. (DHS)

/2008/ The incidence of STD has steadily increased over the last five years and most cases of Chlamydia and gonorrhea are reported among 15-19 years old, especially females. Adolescents do not usually seek medical attention, increasing the probability for those with untreated infections progressing to serious reproductive and other health problems. DOH plans to implement annual Chlamydia and gonorrhea screenings in two high risk DC senior HS in September 2007. See HSI # 05A. //2008//

/2009/ The highly successful Chlamydia and gonorrhea screenings are in all DC Public high schools. //2009//

/2010/ STD screening with a focus on Chlamydia and gonorrhea in District public high schools continued in 2009. In 2010 it will expand to all HS.

During the MCH Town Hall Meeting peer counselors suggested that testing be offered at after school events and other teen venues.

CHA continues to collaborate with HAA to promote STD and HIV/AIDS testing among DC adolescents. //2010//

8. Decrease infant mortality. (ES)

/2008/ The new MOM unit provides early identification of high-risk pregnant women who are not yet enrolled in prenatal care providing preventive services such as screening for breast and cervical cancer, STDs, and chronic medical conditions. Women receive assistance with applying for benefits such as Medicaid, TANF, and SSI (if eligible) to remove any financial barriers that may prevent them from utilizing primary and preventive health services. See SPM # 4, 6, 7, 9 and SOM # 1. //2008//

/2009/ Development of the DC Infant Mortality Plan is major priority of Mayor Fenty. //2009//

/2010/ The Perinatal and Infant Health Bureau continues its Advisory Board. In 2010 the plans include evaluation of the Healthy Start Program; Family Support Worker program; collaboration with DC Jails, shelters and Child and Family Services Agency to identify pregnant women in first trimester and refer to services. It also launched it public information campaign "I am a Healthy DC Mom" a broad based education and service project to support pregnant and new moms, keep them fit, and keep infants safe.

A new vendor will provide safe cribs (15,000-18,000) under the First Candle Program starting this summer.

Despite budget cuts $1 M in locals funds are dedicated to improving perinatal outcomes. /2010//

9. Improve school-based asthma management of children (ES)

/2008/ MPCA has an agreement with the National Capital Asthma Coalition (NCAC) for

asthma training for over 6,000 children, adults, and professionals at over 80 community workshops and health fairs each year. . See HSCI # 07A and SPM # 2. //2008//

/2009/ Child Health Action Plan targets asthma management decreased ED visits by 20% by 2010; implement QI plans and asthma protocols in school education initiatives. //2009//

/2010/ ALA DC is directing the DC Asthma Partnership, as the NCAC has closed its doors. A school based quality improvement program with practitioners is in process. Also, the DC Asthma Surveillance Report was published this spring along with the "DC Strategic Plan for Addressing Asthma 2009-2013". //2010//

10. Decrease lead poisoning for children under six years of age. (PBS)

/2008/ The Childhood Lead Poisoning, Screening, and Education Program (CLPSEP) served a total of 16,028 individuals in FY 2006.CLPSEP used the DC DOH Lead Mobile Health Unit to provide screening, outreach and educational activities. The program improved the screening rates among the various MCOs from 54% to 63.8%. See SPM # 3. //2008//

/2009/ Conducts home based assessment of children with blood lead levels at or equal to 5 ug/dl. //2009//

/2009/ DC Partnership to improve Health Care Quality is working with MAA to develop the EPSDT well child registry. In January DC will release a new Birth Certificate that will increase data collection at the person level.

The CSHCN advisory board will increase membership, youth and citizen involvement. CHA will add a parent advocate to AMCHP advisors. //2009//

/2010/ The DDOE Lead Program has expanded it outreach to conduct home based assessment through a collaborative effort with the Perinatal and Infant Health Bureau. Women are referred to the Lead Program and the home is assessed for dust and lead. Education on the effects of lead and the need for screening is presented to the mom.

It also established a new effort with the school nurse program. The nurse will submit any health form questionnaire where the question on lead is blank, DDOE will then follow up.

DC leads US legislation by defining paint hazard. //2010/
An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	98
Annual Indicator	100.0	NaN	100.0	100.0	86.0
Numerator	33	0	30	30	43
Denominator	33	0	30	30	50
Data Source					Newborn Screening Program
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	95	95	96	96

Notes - 2008
Realignment in CHA, as well as loss of some key personnel, left the program with less documentation than in previous years. The previous administration did not have procedures in place for properly storing or archiving data on follow-up of positive screens. There was also no way to reconstruct the missing data after the fact. Therefore precautions need to be in place now. CHA is looking into other data retrieval mechanisms as well as data storage mechanisms. One DOH employee will maintain the quality of the data and the data wil be stored in a central location.

Notes - 2007
2007 data is not available at this time and will be updated.

CHA discovered previously that the wrong information was being entered from Form 6. This is noted and will be corrected in the future.

Notes - 2006
CHA discovered during the 2009 application process that the wrong information was being entered from Form 6. Instead of reporting the % of positive screens, the table was reporting the % of total screens. This is being corrected.

a. Last Year's Accomplishments
To address the National Performance Measure 01 the DOH:
1) Continued its Healthy Start Program and Hospital Newborn Discharge Program to ensure that each District newborn receives a follow-up visit within 48 hours of birth and within 1 month.

2) Case managers assist patients in enrollment in a case management program either through the Medicaid managed care program or through the HCSN managed care program.

3) Implemented the Child Health Action Plan strategies to support the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs include:

In support of well child visits for children 0-21 years old, activities included:
a) continued implementation of the standard medical record form (SMRF) in all pediatric practices
b) conducted education of all pediatric primary care providers on HealthCheck Database regarding the SMRF.
c) conducted audits of metabolic screen files.
d) assured that every child with SHCN has a primary care provider
e) Increased access to subspecialty care

4) Continued the follow up for children with abnormal screens by enhancing case management. Every infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening currently receives short term follow-up from identification to specialty referral. These infants are followed to diagnosis. The Newborn Metabolic Screening (NMS) program is currently in the process of developing a long-term follow up protocol, allowing care-coordinators to provide enhanced follow up beyond disorder identification to ensure continued comprehensive,

coordinated care and treatment for those infants affected. Early identification and appropriate and continuous treatment is vital to the addressing the morbidity and mortality of these infants.

5) Continued projects include DC Linkage and Tracking System Program integrated into the hospital discharge and Healthy Start Programs.

6) Perinatal Health Advisory Committee - focused on conducting a meaningful and comprehensive evaluation of Healthy Start and other existing parenting oriented programs in DC with the goalof optimizing parenting services offered. It will iIncorporating systemic assesement of pychsocial and behavioral risk and protective factors as a part of perinatal, infant and prenatal and intraconceptual pratice. It will establish mechanisms to identify women with protective factors and those high reproductive risk; identify cost effective approaches to preconceptual and intraconceptual care for women and men of child bearing age. The charter is for 2 years, after which it will be evaluated.

7) Healthy Start Conference -- developed and implemented a conference to promote healthier communications through effective networks. 152 participants comprised of providers, nurses, educators, social workers and outreach workers.

8) Activities related to the Infant Mortality Action Plan. included:
• Institutionalize and expand pilot program to improve discharge planning and linkage to appropriate medical and social services for women admitted to birthing hospitals with inadequate prenatal care and at risk for domestic violence, substance abuse or other factors that negatively affect infant development.
• Facilitate linkage to tobacco cessation programs for all at-risk mothers.
• Compile perinatal screening risk information into a perinatal data registry in order to increase utilization of risk data by clinicians and case managers caring for all newborns and their mothers.
• Commission a comprehensive study of factors associated with infant death and developmental disability for Medicaid beneficiaries in the District of Columbia and identify novel population-based preventive activities and individual health care interventions that will reduce infant mortality

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maternal and Child Health Advisory Group			X	
2. Healthy Start Conference			X	X
3. Family Support Worker Program	X			
4. Case Management Program	X	X		
5. Perinatal Advisory Board - goal optimizing parenting services offered incorporating systemic assessment of pychosocial and behavioral risk and protective factors as a part of perinatal, infant and prenatal and intraconceptual pratice			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Update of PIHB activities:
1) Increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC Health Care Alliance through outreach

programs at WIC, DC Jail, and DCPS in collaboration with school nurses;

2) Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge through Family Support Worker and Home Visitation Program.

3) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency.

4) Facilitate outreach and linkages to care for homeless pregnant women and those living in a shelter.

5) Activities related to CHild Action Plan, subsection Infant Mortality Action Plan

6) Launched public information campaign for pregnant women and moms.

c. Plan for the Coming Year

1) Continue Healthy Start Program and Hospital Newborn Discharge Program to ensure that each District newborn receives a follow-up visit within 48 hours of birth and within 1 month.

2) Case managers assist patients in enrollment in a case management program either through the Medicaid managed care program, WIC and teen pregnancy programs.

3) Continue utilization of the family support workers to provide complementary support services that address medical, social, and psychological risk factors affecting pregnant and parenting women and their children.

4) Performance measures for 2010 include: Continuing follow-up for children with abnormal screens by enhancing case management to ensure that each infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening receives short term follow from identification to specialty referral. These infants are followed to diagnosis. The PIHB will continue to develop and implement a process for the long-term follow up protocol, allowing care-coordinators to provide enhanced follow up beyond disorder identification to ensure continued comprehensive, coordinated care and treatment for those infants affected. Early identification and appropriate and continuous treatment is vital to addressing the morbidity and mortality of these infants.

5) continue its collaboration with DC Jail and schools for the early identification of pregnant teens and women and refer them to health care services as well as entitlements.

6) Continue media campaign.

7) Host a follow- up Healthy Start Conference to address progress in communications and strategies to improve outcomes.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	56.5	57	57.5	58	58
Annual Indicator	55.5	55.5	55.5	53.1	53.1

Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	58	58	58	58	58

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1. The Sickle Cell Program continues to support families' in decision making at each level of their child's care.
The "Faces of our Children" Program is a partnership with a local organization focusing on sickle cell disease education to conduct outreach and education activities. It supports teens understanding of the importance of genetic counseling services.

2. Subgrant to Advocates for Justice to develop and implement the " Parent Information Network" grant that supports families' partner in decision making at all levels.

3. The PIHB Bureau's Epilepsy program established a partnership with the District's managed care organizations to ensure children with special healthcare needs such as those suffering from epilepsy and seizure disorders receive coordinated care within a medical home. The MCOs provide care coordination, support group meetings, educational sessions and mailings, service satisfaction/needs assessment, phone surveys, community forums, and support for children and youth to attend camps during the summer.

4) Collaborate with DDOE Lead Program to provide education to families to mitigate dust and lead in homes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PIHB Case Management program	X	X		
2. PIHB Family Support Worker program	X			
3. CSHCN Advisory Board			X	
4. CHA continued collaboration with Family Voices			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Monitor and evaluate the Parent Information Network.

2) Continue to advocate and support the sickle cell and epilepsy programs.

3) Facilitate the replacement of current hearing screening equipment in hospitals and birthing centers to equipment that des require an audiologist to interpret screening results.

4) Autism and Aspergers - award a sub grant to address service gaps.

c. Plan for the Coming Year

1. Evaluate the objectives and efforts of the Parent Information Network vendor to determine exercising the option year of the contract.

2) Explore strategies with OSSE to improve follow-up with children with posiive hearing screening. Continue to distribute information to hospitals for parents whose child does not pass their initial hearing screening.

3) Autism and Asperger's sub grant - sub grant award to increase capacity of parents with children with autistic spectrum disorder to identify and access relevant resources. Also to assure the capacity for programs caring for children to provide the apprioriate levels of care.

4) CHA will engage with DHCF to look at funding streams for privately insured patients whose coverage does not adequately cover the goods or services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	42.5	43	43.5	44	44
Annual Indicator	41.4	41.4	41.4	36.9	36.9
Numerator					

Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	40	40	40

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
1) Issued a request for application (RFA) to provide transition case management services for children with special health care needs to facilitate their transition from pediatric to adult care. The scope of work includes a parent peer counselor working with families and children through a community based organization.

2) Parent Infant Network continues to expand from the pilot phase to implementation phase. The scope of work includes expansion of navigation services to families with children with special needs; help desk, or resource directory of state and regional services for children with special health care needs, etc.

3) Awarded a subgrant to conduct a gap analysis of early identification of Autism and strategies to increase capacity of parents with children with autistic spectrum disorder to identify and access relevant resources. Also, to assure the capacity for programs caring for children to provide the apprioriate levels of care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. PIHB Case management services	X	X		

2. SHCN managed care organization case management services		X	X	
3. Family Support Worker Program	X			
4. HRSA Grant to CNMC to pilot a medical homes mode to assist families with children special needs	X		X	
5. CHA continued collaboration with Family Voices			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Monitoring of grant award for the Parent Infant Network
2) Collaborating with DHCF to ensure health coverage and services for children and families with SHCN as they transition through life stages.
3) Collaborating with DCPCA to ensure families with SHCN are included in strategies for medical homes, including sufficient number of qualified providers.

c. Plan for the Coming Year

1) Monitoring of grant award for the Parent Infant Network and other subgrants
2) Continue collaboration with DHCF to ensure health coverage and services for children and families with SHCN as they transition through life stages.
3) Continue collaboration with DCPCA to ensure families with SHCN are included in strategies for medical homes including sufficient number of qualified providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	61	61.5	62	62.5	62.5
Annual Indicator	55.9	55.9	55.9	62.7	62.7
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	63	63	63	63	63

Notes - 2008

This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to

generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2006
Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments
The Perinatal and Infant Health Bureau continued the Healthy Start Program and MOM van outreach efforts to enroll pregnant and parenting women in entitlement programs.

Collaborated with DC Jail and DC shelters to provide services to pregnant women and coordinated access to entitlements.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with DC Department of Health Care Finance - Medicaid Program			X	
2. Collaboration with DC Department of Health Care Finance - Alliance Program			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) Healthy Start case management program to facilitate access to enititlements
2) Referral of children with positive hearing screens for follow-up services
3) Collaboration with Lead Program to facilitate access to homes to asses for dust and lead exposure

c. Plan for the Coming Year
Continue the Healthy Start Program and MOM unit outreach efforts to enroll pregnant and parenting women in entitlement programs.

Continue the collaboration with DC Jail and DC shelters to provide services to pregnant women and coordinate access to entitlements.

Continue the collaboration with DDOE Lead Program to identify homes where children are at risk.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	71.5	72	72.5	73	73
Annual Indicator	69.9	69.9	69.9	88.8	88.8
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

Notes - 2006
The data reported in 2006 are pre-populated with the data from the 2001 CSHCN survey.

a. Last Year's Accomplishments
The year's accomplishments included:

1) Continued collaboration with the MCOs and DHCF.

2) Expanded the Parent Information Network Program to include training parent peer counselors to facilitate navigation services to more than 100 families of special needs children.

3) Developed an Autism RFP in preparation of a sub grant award to conduct a gap analysis of early identification of autism.

4) Convened Children with Special Health Care Needs Advisory Board comprised of parents, advocates and providers; developed strategic plan as well as held a mini retreat. Also conducted a self assessment survey of Board members.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Parent Information Network			X	
2. CSHCN Advisory Board			X	
3. Healthy Start program	X		X	
4. Support CNMC Family navigator/Medical Homes program.	X		X	
5. Continued collaboration with Family Voices			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1) Collaborating with MCOs

2) Collaborating with Dept of Health Care Finance to support increased efforts for well child visits

3) Develop RFP for Autism and Aspergers Syndrome program

4) Collaborating with Children's National Medical Center as they implement their HRSA funded pilot program for Family Navigators that will work with families of children with special needs.

5) Collaborating with the Advocates for Justice and Education as they develop the DC Parent Information Network.

c. Plan for the Coming Year
1) Continue the collaboration with MCOs

2) Continuing collaborating with Dept of Health Care Finance to support increased efforts for well child visits

3) Award a sub grant for Autism and Aspergers Syndrome program

4) Continue to collaborate with Children's National Medical Center as they implement their HRSA funded pilot program for Family Navigators that will work with families of children with special needs

5) Award a sub grant or contract to re-establish the PRAMS survey

6) Collaborate with DC Family Voices and the DC Parent Information Network to help ensure that community based systems of care are organized and easily available to families of CSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	5.8	8	8.5	9
Annual Indicator	5.8	5.8	5.8	24	24
Numerator					
Denominator					
Data Source					CSHCN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	25	25	25	25

Notes - 2008
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.
2005/2006 Revisions & Changes:
In the 2005-2006 version of the NS-CSHCN, significant wording changes and new additions were made to the set of questions used to assess Transition to Adulthood. The result is an improved and more robust assessment of this important concept. The 2001 version of the outcome is based on CSHCN ages 13-17; the 2005/06 outcome is calculated for CSHCN ages 12-17. Take these changes into consideration when comparing results across survey years. See Additional Notes section below for more details.
Additional Notes:
The Transition to Adulthood summary measure is a composite score derived from two different subparts based on 8 different survey items. Technical expert panel review of the 2001 NS-CSHCN methods for assessing transition to adulthood led to significant revisions and additions to the 2005-2006 version of these questions. In particular, filter questions were added to identify CSHCN who needed the services being assessed and a new question was added to assess whether health care providers help CSHCN to take increasing responsibility for self-care.

Notes - 2007
This is an interim year for the CSHCN survey and indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. The next survey is scheduled to begin in 2009.

2005/2006 Revisions & Changes:
In the 2005-2006 version of the NS-CSHCN, significant wording changes and new additions were made to the set of questions used to assess Transition to Adulthood. The result is an improved and more robust assessment of this important concept. The 2001 version of the outcome is based on CSHCN ages 13-17; the 2005/06 outcome is calculated for CSHCN ages 12-17. These changes need to be considered when comparing results across survey years.

Additional Notes:
The Transition to Adulthood summary measure is a composite score derived from two different subparts based on 8 different survey items. Technical expert panel review of the 2001 NS-CSHCN methods for assessing transition to adulthood led to significant revisions and additions to the 2005-2006 version of these questions. In particular, filter questions were added to identify CSHCN who needed the services being assessed and a new question was added to assess whether health care providers help CSHCN to take increasing responsibility for self-care.

Notes - 2006
Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments
Convened CSHCN Advisory Board comprised of parents, advocates and providers. A self assessment survey was conducted among the Board members.

Monitored the Parent Information Network activities.

Coordinated referrals with OSSE related to special needs such as hearing services.

Developed an RFP targeted at community based organizations to utilize parent counselors who will help parents navigate the system

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support CNMC with their HRSA-funded grant to pilot a medical homes program to assist families with children special needs	X		X	
2. Parent Information Network	X		X	
3. Parent Peer Counseling Program	X		X	
4. Continue Universal Call Center			X	X
5. Collaboration with OSSE related to SHCN		X	X	
6. MCH Title V Town Hall meeting			X	
7. Subgrant/contract for conducting Needs Assessment			X	X
8.				
9.				
10.				

b. Current Activities
1) Monitor of Parent Information Network activities

2) Support and participate on the CSHCN Advisory Board

3) Convene and lead the MCH Title V Town Hall Meeting to discuss the gaps in services for children with special needs, as well as other topics.

4) Universal Call Center directs residents to specific services, include perinatal information.

5) Collaborates with CNMC as it launches their HRSA-funded Family Navigator Program.

6) Review previous Needs Assessments from other states (online as well as through HRSA MCHB divsion contacts).

7) Develop a Request for Proposals for the Title V Needs Assessment.

8) Select and monitor a subgrantee for the MCH Needs Assessment.

c. Plan for the Coming Year

1) Continue to monitor and evaluate the performance and outcomes of Parent Information Network activities.

2) Continue to support the CSHCN Advisory Board.

3) Convene an MCH Title V Town Hall Meeting in conjuntion with the 5 year Needs Assessment to discuss the gaps in services for children with special needs, as well as other topics.

4) Continue the Universal Call Center directs residents to specific services, including perinatal services.

5) Continue to collaborate with CNMC as its launches their HRSA funded Family Navigator Program

6) Continue to monitor and evaluate the performance and outcomes of the Needs Assessment contract.

7) Select and moniter a Needs Assessment awardee.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85	70	80	82	82
Annual Indicator	82.5	73.5	78.4	83.4	85.4
Numerator					
Denominator					
Data Source					CDC NIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008

Children in the Q3/2007-Q2/2008 National Immunization Survey were born between July 2004 and January 2007.

Estimates are based upon (the immunization schedule) 4:3:1:3:3 plus 1 or more doses of varicella vaccine.

SOURCE: Center for Disease Control and Prevention's National Immunization Survey http://www.cdc.gov/Vaccines/stats-surv/nis/tables/0708/tab02_antigen_iap.xls

This reporting year, the The DC Immunization Program received an award at the National Immunization Conference from March 30 – April 2, 2009 in Dallas, TX, for having the Highest Immunization Coverage amongst Grantees in Urban Areas for 4:3:1:3:3:1 series (4 or more doses of diphtheria and tetanus toxoids and acellular pertussis vaccine, 3 or more doses of poliovirus vaccine, 1 or more doses of MMR vaccine, 3 or more doses of Haemophilus influenzae type b vaccine, 3 or more doses of hepatitis B vaccine, and one or more doses of varicella vaccine).

The Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B increased from 83.4 percent in 2006, to 85.4 percent in 2007 an increase of 2.4 percent.

Notes - 2007
Estimates are based upon 2007 Q3-2006 to q2 007. Children were born between July 2003 and December 2005. ††† 4:3:1:3:3 plus 1 or more doses of varicella vaccine.http://www.cdc.gov/vaccines/stats-surv/nis/tables/0607/tab09_

Notes - 2006
Estimates are based upon 2006 NIS. National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months - United States, 2006 Source: MMWR, September 15, 2007 /http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab02_antigen_iap&qtr=Q1/2006-Q4/2006The 2005 NIS survey cohort included Children in the Q1/2006-Q4/2006 National Immunization Survey were born between January 2003 and June 2005; Rate shown is for four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, three or more doses of HepB 4:3:1:3:3: series 95% CI +/- 6.

a. Last Year's Accomplishments
1) Collaborated with DCPS and Charter school nurses to maintain immunization levels for children enrolled in Head Start programs, as well as school aged children.

2) Healthy Start Program counsels pregnant and parenting women on the importance of childhood immunizations and assists them with access to pediatric services including transportation to and from provider offices.

3) Monitored the Immunization Registry data collection and reporting to ensure that DOH will continue to meet its immunization performance measures.

4) Distributed Vaccines for Children to providers throughout the District.

5) Maintained levels of immunization compliance in Public and Charter schools as well as in licensed child development centers and Headstart centers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DOH collaboration with DHCF to increase well child visits			X	X

2. Healthy Start Program	X			
3. Family Support Worker Program	X			
4. Public health campaign " I am a Healthy DC Mom"			X	
5. Perinatal Advisory Board - goal optimizing parenting services offered incorporating systemic assessment of pychosocial and behavioral risk and protective factors as a part of perinatal, infant and prenatal and intraconceptual pratice			X	
6. Collaboration with HEPRA re: H1N1 school children protocols including school closures, treatment protocols and vaccines	X		X	X
7. Collaboration with schools and Head Start Programs	X		X	
8.				
9.				
10.				

b. Current Activities

1) Work with the School Nurses and Administrators of the Public, Charter, Parochial and Private schools to assure high immunization rates in the face of new regulations. The Immunization Program staff work with the Health Regulation Administration to provide data needed to enforce immunization compliance for licensed child development centers and Head Start centers and assure staff at these facilities are informed of the new regulations. Letters are sent to parent and schools announcing the new immunization requirements.

2) Evaluating the current immunization compliance rates in Private and Parochial schools by working closely with school health officials and staff from the Health Regulations Administration.

2: Assure maintenance of the immunization registry by working with senior officials in the Department of Health.

3. Continue to develop practice based improvement strategies for immunization rates for cxhildren 0-4 years of age.

4. Public campaign "DC Health Mom" component includes importance of screenings and immunizations.

5. Healthy Start and Family support program continues its outreach and education of parents.

6. Collaborated with HEPRA related to H1N1 protocols for school age children, including school closures and vaccine issues.

c. Plan for the Coming Year

1) Work with the School Nurses and Administrators of the Public, Charter, Parochial and Private schools to assure high immunization rates in the face of new regulations.

2) Develop strategies to ensure current immunization compliance rates in Private and Parochial schools by working closely with school health officials and staff from the Health Regulations Administration

2: Assure maintenance of the immunization registry by working with senior officials in the Department of Health.

3. Continue to develop practice based improvement strategies for immunization rates for children 0-4 years of age.

4. Continue the public information campaign "DC Health Mom" component that includes

importance of screenings and immunizations.

5. Continue Healthy Start and Family Support Worker program outreach and education of parents.

6. Continue to collaborate with HEPRA related to H1N1 or other flu epidemic protocols for school age children, including school closures and vaccine issues.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	37.4	34.1	34.1	34.1	32
Annual Indicator	42.2	37.8	38.4	41.1	41.1
Numerator	326	327	372	393	393
Denominator	7717	8648	9681	9560	9560
Data Source					DC 2007 Birth File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	40	40	40

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010.

Source: Numerator is taken from The District of Columbia State Center for Health Statistics 2007 Birth File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2007
Source: Numerator is taken from The District of Columbia State Center for Health Statistics 2007 Birth File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

The birthrate (per 1,000) for District teen mothers ages 15-17 years increased by 5.9 percent from a rate of 38.8 percent per 1,000 live births in 2006 to 41.1 percent per 1,000 live births in 2007.

Notes - 2006

Data will be updated when final 2006 birth file becomes available.

a. Last Year's Accomplishments

1) PIHB continued to provide early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance including DC Jails and shelters;

2) Collaborated with DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge with Home Visitation program;

3) Implemented routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant;

4) Enhanceed linkage to APRA substance abuse education and treatment services;

5) Enhanced community-based screening and prevention services for at risk families and youth served by child protective service agency;

6) Reduce STD and HIV rates in the District of Columbia by partnering with HAA. In FY09, CHA increased classroom and community group sessions with HAA at District of Columbia schools and community youth service organizations. It supported condom distribution in schools by school nurses and provided referral information to youth friendly testing sites during every education session and forum.

7) Continued to support the Center services including a comprehensive array of physical and mental health services as well as health education and support services.

8) Expanded the Carrera Pregnancy Prevention Program model.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Perinatal Advisory Board - goal optimizing parenting services offered incorporating systemic assessment of pychosocial and behavioral risk and protective factors as a part of perinatal, infant and prenatal and intraconceptual pratice			X	
2. School Nurse Program	X			
3. Health and Sexuality Education classes in DCPS and Charter Schools	X	X		
4. Carrera Pregnancy Model program	X			
5. Monitor Child Health Action Plan			X	X
6. Family Support Worker Program	X			
7. Continue 'Girl Talk" and "Healthy Generations" programs to	X			

reduce rapid second pregnancies				
8.				
9.				
10.				

b. Current Activities
Current activities include

1) Working with community partners to implement evidence based approaches to increase the age of sexual initiation.

2) Established programs and procedures that support adolescent parents including "Girl Talk" and "Healthy Generations", such as access to mental health and educational services.

3) Continued health and sexuality education classes that included addressing pregnancy prevention and self awareness sessions with in District of Columbia schools for grades K-12.

4) Continued to reduce sexual initiation by empowering youth through expansion of the Carrera program. The Carrera program is an Adolescent Pregnancy Prevention Program that uses a holistic approach to empower youth. The program helps them develop personal goals and the desire for a productive future, in addition to developing their sexual literacy and educating them about the consequences of sexual activity. Currently, it is implemented in one Public Charter School with plans in development for evaluation and outcomes for 2010.

5) Continues to support the DCPS "Making Proud Choices Curriculum" for all high school students.

c. Plan for the Coming Year
Plans for the coming year include but are not limited to:

1) Continue to working with community partners to implement evidenced based approaches to increase the age of sexual initiation including

2) Continue to support programs and procedures that support adolescent parents including "Girl Talk" and "Healthy Generations".

3) Continue health and sexuality education classes that included addressing pregnancy prevention and self awareness sessions with in District of Columbia schools for grades K-12 and/or support DCPS implementation of health and sexuality education curriculum in all DCPS and Charter schools.

4) Evaluate the outcomes and continue to monitor the Carrera program.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	65	65	65	65
Annual Indicator	10	13.3	3.0	57.6	76.4

Numerator		108	67	49	311
Denominator		812	2259	85	407
Data Source					DC Oral Health Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	80	80	80

Notes - 2008
Numerator : Reflects the number of 3rd graders who received a sealant.

Denominator: Reflects the number of eligible 3rd graders

This reporting period, 13 District of Columbia Public Schools were targeted to receive Oral Health Services. These Schools met the criteria that at least one-half of the student enrollment were eligible for free or reduced lunch program.

The number of eligible students are therefore eligile for the free lunch program and those who returned permission slips were included in oral health program.

Notes - 2007
This reporting period, 6 District of Columbia Public Schools were targed to receive oral heath services (2 more than last year). These schools met the criteria that at least one-half of the student enrollment were eligible for the free or reduced lunch program. Therefore, the number of eligible students (including those who returned permission slips) and including those who used the service remained low. In addition, the schools served had overall small enrollment numbers for third grade classes. The denominator reflects the number of eligible 3rd graders; the numerator reflects the number 3rd graders who received a sealant.

In 2006 the denominator was the number of all eligble children. This caused the annual indicator to be much lower, and therefore was not used again in this reporting year.

It can be noted that DC's oral health program is expanding to provide services in all grades in participating elementary schools.

Notes - 2006
This reporting period, only 4 District of Columbia Public Schools were targed to receive oral heath services. These schools met the criteria of at least one-half of the student enrollment were eligible for the free or reduced lunch program. Therefore, the number of eligible students (including those who returned permission slips) including those who used the service remained low.

a. Last Year's Accomplishments
1) The Oral Health Division was able to successfully expand the School Based Dental Program (Program) by hiring an additional dentist and a community oral health educator (who also provides dental assistance to the additional dentist). As a result, DC Head Start centers and DC Public Schools (DCPS) elementary school students of all grades who presented their signed parental consent forms were provided with preventive oral health services.

2) Schools with at least 50% of its student population enrolled in the National Free or Reduced Lunch Program are targeted by the Program. Dental services are provided in two schools simultaneously. This Program allows students enrolled in schools that meet this criteria with necessary dental services they would not have otherwise had access to.

3) The Department of Health Care Financing, formerly Medical Assistance Administration increased its reimbursement rates to 100% of Medicare for medical and dental providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Oral health exam and sealant program	X	X	X	
2. Oral health education		X	X	
3. Monitor Child Action Plan Oral Health activities for compliance		X	X	
4. DHCF increased Medicaid reimbusement to medical and dental providers to 100% of Medicare rates			X	X
5. Continue to support expanding the role of dental hygienists to practice independently	X		X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Preventive dental services:

- Sealant Application - Sealants are thin plastic materials that are applied to the chewing surfaces of permanent molars; they are most effective in reducing cavities in children with newly formed permanent teeth as usually found in 2nd and 3rd graders (6 - 8 years)
- Fluoride Treatment - Fluoride treatment is used as a preventive measure because it is absorbed into the enamel of the teeth making them more resistant to acid producing bacteria
- Dental Screenings - Helps to build a positive attitude in the student towards dental health, encourage parents to schedule dental examinations for their child, and be used to enhance the health education program
- Oral Health Education & Promotion - Inform students, parents and teachers of the importance of good oral health and advice them on techniques to prevent oral diseases
- Data Collection - The Project serves as a valuable source of original oral health data as the Division, in conjunction with the DC DOH and the District at large, continues to build its oral health data.

2) Oral Health Program continues its efforts to expand the role of dental Hygienists to practice independently.

c. Plan for the Coming Year

1) School-Based Dental Program -- Referral Program

As such, the Division will aim to increase its efforts to more effectively ensure that parents and

guardians are alerted when their child is in need of greater dental care and provided with information of possible dental practitioners they may visit.

2) Continue Sealant Application and Data Collection - for 2nd and 3rd graders (6 - 8 years)
- Fluoride Treatment -
- Dental Screenings -
- Oral Health Education & Promotion -
- Data Collection -

3) Continue to monitor and evaluate the Oral Health Program activities in the DC Child Health Action Plan.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4	3	2	2	2
Annual Indicator	2.1	0.0	4.2	3.2	3.2
Numerator	2	0	4	3	3
Denominator	93747	96217	95176	93980	93980
Data Source					2007 DC Death (Vital Statistics)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3	3	3	3	3

Notes - 2008
The District of Columbia has a 2-year delay for reporting death data. Currently 2007 death data is used to populate information for 2008. The 2008 data will be available in 2010, and this measure will be updated.

Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2007
Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Within the District, although our numbers for deaths to children aged 14 years and younger

remain low ,but still above our annual performance objectiv of no more than 2 deaths per 100,000 children due to motor vehicle accidents. On average the District of Columbia has a low number of deaths within this age range due to motor vehicle accidents.

Notes - 2006
Numerator,: 2006 District of Columbia provisional death file.. Number of deaths to children aged 14 years and younger caused by motor vehicle crashes. This includes all occupant, pedestrian, motorcycle, bicycle, etc. deaths caused by motor vehicles.

Denominator: Source Table 2. Estimates of the Population by Sex and Age for the District of Columbia: April 1, 2000 to July 1, 2006. (SC-EST2005-02-11) Population Division, US Census Bureau.

a. Last Year's Accomplishments
CHA through the Child Health Action Plan evaluated strategies to address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children through an analysis of policies and programs currently in place.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue analysis of appropriate policies and programs for violence and injury prevention including motor vechicle crashes			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Reviewing the Child Health Action Pan strategies to address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children trhough an analysis of policy and programs currently in place.

c. Plan for the Coming Year
Will amend the Child Health Action Plan to incorporate strategies to address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children through an analysis of policies and programs currently in place.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective			40	41	42
Annual Indicator		34.6	28.8	21.8	21.8
Numerator			1352	375	375
Denominator			4695	1722	1722
Data Source					2008 WIC DC Cares Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	25	24	24	23

Notes - 2008
Source: FY 2007 DC Cares-WIC Data base. This data reflects the breastfeeding rates for the District of Columbia's WIC population of women with infants who report breastfeeding at six months of age

Notes - 2007
Source: FY 2007 DC Cares-Women Infants Children (WIC) Data base. This data reflects the breastfeeding rates for the District of Columbia's WIC population of women with infants who report breastfeeding at six months of age.

In the previous year the numbers were an estimate based upon the Pediatric Nutrition Surveillance Program national phone survey on breastfeeding. Reporting actual numbers of serviced clients was deemed to be preferred over numbers taken from a phone survey.

Notes - 2006
Source: FY 2006 DC Cares-WIC Data base. This data reflects the breastfeeding rates for the District of Columbia's WIC population of women with infants who report breastfeeding at six months of age.

a. Last Year's Accomplishments
1. Continued the DC WIC breastfeeding program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level.

2. Distributed to eligible WIC participants: breast pumps, education, and support, either one-on-one, or as a group.

3. Continued to convene monthly Breastfeeding Beautiful Beginning Club meetings.

4. Collaborated with the DC Breastfeeding Coalition to establish breastfeeding friendly hospitals. Karen Watts Director of Perinatal and Infant Health Bureau is the CHA representative on the Coalition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Program supports breast feeding	X			
2. Hospital discharge program	X		X	
3. Healthy Start Case Management Program	X	X		
4. Support Breast Feeding Peer Counseling program	X			
5. Representation on DC Breast Feeding Coalitition			X	
6. Continue Lactation Room located at DOH	X			
7.				
8.				
9.				
10.				

b. Current Activities

1. Continues operating the Lactation Unit and Resource Center and collecting data on breastfeeding mothers. The unit will be evaluated to include more sharing opportunities for mothers to bond. A survey of all users will be available on site to document center use, and satisfaction with the service.

2. Continues the breastfeeding program through the WIC Program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level.

3. Distributes to eligible WIC participants breast pumps, education, and support, either one-on-one, or as a group.

4. Convenes a monthly Breastfeeding Beautiful Beginning Club meetings.

5. Continues collaboration with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.

c. Plan for the Coming Year

1. Continue operating the Lactation Unit and Resource Center and continue to collect data on breastfeeding mothers.

2. Continue breastfeeding program through the WIC Program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level. Expand peer counselors.

3. Continue distribution to eligible WIC participants breast pumps, education, and support either one-on-one, or as a group.

4. Continue to convene monthly Breastfeeding Beautiful Beginning Club meetings.

5. Continue to collaborate with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	100	75	75	80
Annual Indicator	66.7	25.5	22.6	34.6	97.9
Numerator	10417	3871	3175	5452	14199
Denominator	15617	15179	14065	15752	14500
Data Source					AURIS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	98

Notes - 2008
2008 newborn hearing data was obtained from the AURIS database and reporting system. 14,199 screening occurred in 2008. Review of data in both 2007 and 2008 indicate that there are numerous duplicate child records in the system.

The program is working with the contractor is taking steps to eliminate or reduce the number of duplicate records in the system. After removing dulicate records it was found that the information system has data on reported screenings at levels similar to last year.

2008 Birth data is provided by State Center for Health Statistics and is their most recent estimate of all births in the District of Columbia.

Notes - 2007
2007 newborn hearing data was obtained from the AURIS database and linked with the 2007 birth file. Not all birthing facilities have the resources to input directly into the information system.

The program obtains data directly from the hospitals and indicates that 14,995 tests were taken of children born in 2007. It is unclear what is the discrepency between the data reported by the sites and the data inputed into the information system.

Notes - 2006
2006 newborn hearing data has not been linked with the 2006 birth file yet.

a. Last Year's Accomplishments
1) Evaluated different FDA approved hearing screening equipment that does not require an audiologist to interpret.

2) Developed strategies to purchase and replace current hearing screening equipment in hospitals and birthing centers.

3) Continued working with Vital Records to ensure collection of data in birth records. Title V funds used to update the Vital Records data collection requirements.

4) Practioners actually report much higher rates for newborns screened for hearing. DOH continues to work to improve data collection.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perinatal Advisory Board - goal optimizing parenting services offered incorporating systemic assessment of pychosocial and behavioral risk and protective factors as a part of perinatal, infant and prenatal and intraconceptual pratice			X	
2. DC legislation requiring metabolic and hearing screens at the time of birth			X	
3. Referral of newborns with positive hearing screen to OSSE for follow-up and coordination of care	X			
4. Replacement of current screening equipment to an FDA - pproved device that does not require interpretation of screening results by an audiologist	X		X	
5. Public Health Campaign - " I am a Healthy DC Mom" has a screening component			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Replacing current hearing screening equipment to improve referral process.

2) Working to increase data verification of screenings by partnering with Vital Records.

3) Collaborating with OSSE to ensure follow-up in timely manner of infants referred because of positive hearing screen

4): Increase parent's knowledge of hearing loss by providing educational materials.Continue to distribute new brochures to hospitals containing information for parents about failed initial hearing screening.

5) Increasing the integration with the medical home by identifying the Pediatrician/Primary Care Provider prior to discharge. Partnering with the DC hospitals to identify and verify the newborn's primary care provider prior to discharge.

6) Ensuring appropriate developmental progress for children with hearing loss through collaboration with providers and parents.

7) Working to increase parents and childcare providers' knowledge of hearing screening.

8) Coordinating care by partnering with the Infants and Toddlers with Disability Division (ITDD). The Bureau, in collaboration with ITDD and the Special Education units at DCPS and OSSE, will monitor and co-manage children 0 to 3 years of age referred with hearing loss. The collaboration will commence during FY09.

c. Plan for the Coming Year
The activies for coming year include:Plan for the Coming Year

1): Increase parents and childcare providers knowledge through education on developmental milestones.
An Audiologist will educate and conduct training sessions for parents and early child care providers regarding age-appropriate milestones for speech and language development.

2) Increase coordination of care by partnering with the Infants and Toddlers with Disability Division (ITDD).
The Bureau, in collaboration with ITDD and the Special Education units at DCPS and OSSE, will monitor and co-manage children 0 to 3 years of age referred with hearing loss. The collaboration will commence during FY09.

3) Continue to working with Vital Records to ensure collection of data in birth records. Title V funds will be used to update the Vital Records data collection requirements.

4) Replacing hearing screening equipment in all hospitals and birthing centers.

5) Continue to collaborate with OSSE to improve follow-up timeframe for infants with a hearing loss.

6) Continue medical home integration project for children with special needs.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	6	6	6	6
Annual Indicator	10	6.9	7.8	7.8	8.0
Numerator		7697	9221	9221	9090
Denominator		111967	118104	118104	113720
Data Source					State Health Faces and Census data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	6	6	6

Notes - 2008
Numerator: 2007 District of Columbia: Health Insurance Coverage of Children 0-18, states (2006-2007), U.S. (2007)
www.stateheathfacts.org

Denominator: The Untied States Census Bureau, 2007 American Community Survey Population

Estimates for the District of Columbia.
http://www.census.gov/popest/states/asrh/tables/SC-EST2007-02-11.xls

Notes - 2007
Data for 2007 is not available, when it becomes available, this measure will be updated.

Notes - 2006
http://www.statehealthfacts.org/profileind.jsp?ind=203&cat=4&rgn=10.

a. Last Year's Accomplishments
1) Continued the Healthy Start and MOM unit programs
2) Expanded the Family Support Worker program that conducts outreach to pregnant and parenting women and assists with enrollment to entitlement programs.
3) Expanded collaboration with DC Jails and Shelters to identify pregnant women

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health Start Program refers pregnant women and new moms to appropriate benefit and entitlement services	X			
2. DC Alliance provides health care coverage to those that do not meet eligibility requirements			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
1. Continue the Healthy Start, MOM unit and other outreach programs to enroll eligible pregnant and parenting women in insurance and other entitlement programs.

2. Expanding its collaboration with DC Jail and Shelters.

3. Continuing collaboration with DHCF for early idemtification of pregnant women by Medicaid and Alliance entitlements.

c. Plan for the Coming Year
CHA will continue:

1. Healthy Start, MOM unit and other outreach programs to enroll eligible pregnant and parenting women in insurance and other entitlement programs.

2. to collaborate with DC Jail and Shelters to identify pregnant and parenting women.

3. to collaboration with DHCF for early identification of pregnant women by Medicaid and Alliance entitlements.

CHA will request technical assistance to collaborate with Medicaid on implementing the Katy Beckett waiver to provide emergency funds to parents of special needs children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			13	13	12
Annual Indicator		12.8	14.6	14.6	14.6
Numerator			812	791	791
Denominator			5563	5419	5419
Data Source					District of Columbia PedNSS 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	12	12	12	12

Notes - 2008
Source: District of Columbia PedNSS 2007. Currently 2008 data will not be available until July 2009. This information is based on the District's WIC children.

When data becomes available, this measure will be updated.

Notes - 2007
We currently have only the PedNSS 2007 available. 2008. This information is based on WIC Children. When new information becomes available ths measure will be updated.

Notes - 2006
The data indicated here is for 2005. Because this represents the first year that The Districts' WIC program has collected this data. When 2006 data becomes available, this measure will be updated.

a. Last Year's Accomplishments
1. DC Obesity Inter-Agency Work Group was initiated to gather information about obesity prevention activities of DC government.

2. The Workgroup developed the State Plan on Childhood Obesity.

3. Nutrition and Physical Fitness Bureau continued:

- the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

- to support the DC Action for Healthy Kids - is a volunteer-based group of local stakeholders committed to creating a healthier school environment for youth and children in D.C. by engaging schools in actions that foster sound nutrition.

- supported the Preventive Service Block Grant supported expansion of "I'm Moving I'm Learning" Program to all the Child Development Centers.

- the Healthy Corner Store Initiative, researching ways and developing social marketing materials to increase access to healthy foods in Ward 8 corner stores;

- the Sister Circles, piloted in Wards 5,6,7, and 8 as a vehicle for supporting African American women 40-70 years of age to reduce stress, improve eating habits, and exercise more.

4) New food vendor contract was signed that includes improved nutrtional school meals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expansion of "I am Moving, I am Learning" fitness program to all child development centers	X			
2. Public Health Campaign - " I am a Healthy DC Mom"			X	
3. Partnership with DCPS and OSSE resulted in adding physical education to school and after school program curriculum	X	X		
4. New food vendor contract that includes improved nutritional school meal programs		X	X	
5. Local funds continue to support grants to address childhood obesity	X		X	
6. Plans to complete State Plan on Childhood Obesity by Oct 2009		X	X	
7.				
8.				
9.				
10.				

b. Current Activities

1) Collaborating with Department of Health Care Finance (DHCF) to assure adequate access to care for individuals with obesity or at-risk for obesity. CHA is working with Medicaid to rectify these issues in FY 2009.

2) The Childhood Obesity State Plan is being completed and will be published in Oct 2009. DOH is also developing a State Plan on Obesity Prevention and Reduction, in collaboration with the citywide Obesity Work Group. The State Plan, scheduled for completion by the end of FY2009, will be created with substantial engagement from key stakeholders, and will include structured community dialogues, focus groups, and other mechanisms to ensure significant input from District residents and other stakeholders.

3) Improving quality of primary care services for identification, treatment and prevention of obesity by implementing a quality improvement initiative. DOH partnering with Medicaid in the development and conduction of Obesity Primary Care Quality Improvement Training Program. This includes facilitating the dialogue between the MCOs and Medicaid in how to develop an evidence-based quality improvement initiative to encourage identification, prevention and treatment of obesity in children and families.

c. Plan for the Coming Year
Plans for 2010 include, but are not limited to:

1. Continue to collaborate with DHCF to assure adequate access to care for individuals with obesity or at-risk for obesity.

2. Publish and distribute the Childhood Obesity Prevention and Reduction Plan.

3. Continue to collaborate with DCPS, OSSE and child development centers to promote nutrition and physical education.

4. Continue to collaborate with DHCF to promote comprehensive services for children and related funding.

5) Continue the 2009 initiatives:

- " I am Moving I am Learning" curriculum, a nationally recognized and tested system of physical activity and nutrition services improvement in child development center;

- the Healthy Corner Store Initiative, researching ways and developing social marketing materials to increase access to healthy foods in East of the River (Wards 7 and 8) corner stores;

- Sister Circles, piloted in Wards 5,6,7, and 8 as a vehicle for supporting African American women 40-70 years of age to reduce stress, improve eating habits, and exercise more.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Notes - 2008
Currently the District of Columbia Birth Certificate does not collect smoking data per trimester of pregnancy. However, The pilot for the implementation of the 2003 Birth Certificate started in Jan of 2009 and full implementation is now in effect as of the end of March 2009. In the future the District will have the capacity to collect and report on smoking by trimester.

Notes - 2007
We do not collect smoking data per trimester of pregnancy.

Notes - 2006
This information is not captured on the Vital Statistics Birth record. We are unable to provide information.

a. Last Year's Accomplishments
1. Continued to provide counseling pregnant and parenting women on health effects of cigarette smoking by Healthy Start case managers and family support workers.

2. Continued to work with community agencies, American Lung Association of DC (ALADC) and APRA in support of smoking cessation.

3. Vital Records forms was updated to accurately capture smoking data.

4. Continue to work with community agencies, ALADC and APRA in support of smoking

cessation.

5. The new birth certificate collects alcohol consumption, as well as smoking in the last trimester of pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Public Health Campaign - " I am a Healthy DC Mom" - discusses issues to keep mom and baby healthy			X	
2. Healthy Start case management program counseling pregnant women not to smoke	X	X		
3. Family Support Worker program supports counseling program	X		X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Continue counseling pregnant and parenting women on health effects of cigarette smoking.

2) Continue to work with community agencies, ALADC and APRA in support of smoking cessation.

3) Continue to use new birth certificate to collect smoking and alcohol consumption data in the last trimester of pregnancy.

c. Plan for the Coming Year

The plans for 2010 include:

1. Continue counseling pregnant and parenting women on the health effects of cigarette smoking.

2. Continue to work with community agencies, ALA DC and APRA in support of smoking cessation.

3. Continue to collect smoking as well as alcohol consumption in the last trimester of pregnancy from the revised birth certificate (Vital Records)

4. Cotinue the public information campaign "I am a Healthy DC Mom", which will also educate women on the smoking issues during pregnancy and impact on infants and children.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	6	6	5	5
Annual Indicator	3.9	2.6	0.0	2.5	2.5
Numerator	1	1	0	1	1
Denominator	25929	38600	39628	40355	40355
Data Source					DC 2007 Death Data (Vital Statisitcs)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3	3	3	2	2

Notes - 2008
The District of Columbia has a 2-year delay for reporting death data. Currently 2007 death data is used to populate information for 2008. The 2008 data will be available in 2010, then, this measure will be updated.

Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2007
The number of suicide deaths among youth , where in the death certificate lists cause of death as suicide, consistently remains low in the District of Columbia.

Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2006
Source: 2006 District of Columbia death file
There were 0 suicide deaths in 2006 for the 15-19 year olds.

a. Last Year's Accomplishments
The rate of deaths for this age population, where in the death certificate lists cause of death as suicide, consistently remains low in the District of Columbia.

CHA programs that affect teen suicdes in youths included:

1) Provided child safety sessions on Good Touch/Bad Touch.

2) Continued ICSIC's goals to stay in school and identify children at risk for behavioral health issues.

3) Continued full service middle school pilot program to include preventive and mental heath services. Staff includes a school nurse, psychologist, and detention specialist.

4) Continued the Carrera Program focused in increased self efficacy and decreased mental health issues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analysis of policies that mitigate suicide deaths among youth			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The number of deaths from suicides cannot be reported because the DC State Center for Health Statistics has not released the number of deaths in 2008. Tge 2007 data is repeated.

THe number of homicides in the distict far outpasses the number of suicides. However we cannot tell how many homicides were the result of a suicidal pact i.e. having someone else kill you rather than you kill yourself. There is no agency that colkects this information.

The current activities include but are not limited to:

1) Carrera Program focuses on increased self efficacy and decrease mental health issues.

2) Analysis of policies that impact suicide deaths among youth.

c. Plan for the Coming Year
1. Evaluate the effectiveness of Carrera Program.

2. Continue collaborative efforts with the school nurse program and Department of Mental Health and APRA to identify at-risk teens.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	79	80	80	80	80
Annual Indicator	76.8	79.0	81.6	76.0	76.0
Numerator	169	169	177	196	196
Denominator	220	214	217	258	258
Data Source					2007 DC Birth File (Vital Statistics)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	80	85	81

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007
The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates increased from 81.6 percent in 2006 to 99.0 percent in 2007, an increase of 21.3 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator reflects the number of very low birth weight infants delivered at District hospitals with neonatal intensive care units were included.

The denominator reflects the total number of District very low birthweight births.

Notes - 2006
Data will be updated when final 2006 birth file becomes available.

a. Last Year's Accomplishments
Very low birthweight babies are born weighing less than 1,500 grams causes by premature birth The child has less time in the mother's womb to grow and gain weight. This often lead to disabilities or birth defects.

1. Supported the "Faces of Our Children" program that supports Sickle Cell families in decision making at each level of their child's care. This local partnership focuses on Sickle Cell parents who are a high risk group, and educates teens about the importance of genetic counseling

services before conception.

2. Monitored the Parent Information Network grant which was to make resouces available on various conditiosn including the risks of low birth weight and high risk births.

3. Monitored the Epilepsy program that provides eduacation to parents about epilepsy and high risk deliveries. The Epilepsy Foundation also established a partnership with the District's managed care organizations to ensure children suffering from epilepsy and seizure disorders receive coordinated care within a medical home. The MCOs provide care coordination, support group meetings, educational sessions and mailings, service satisfaction/needs assessment, phone surveys, community forums, and support for children and youth to attend camps during the summer.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Start case management services	X			
2. Family Support workers in Wards 5,6, 7, 8	X			
3. Home visitation legislation requiring home visits within first 48 hours of delivery	X			
4. Public Health Campaign - " I am a Healthy DC Mom" - discusses issues to keep mom and baby healthy				
5. Outreach programs to pregnant women incarcerated in DC Jail	X			
6. Outreach programs to pregnant women living in shelters	X			
7. Health Start Conference convened to discuss healthier pregnancy outcomes and strategies			X	X
8.				
9.				
10.				

b. Current Activities

Any baby born prematurely is more likely to be very small. African American and teens are more likely to have a low birth weight infant.

1. Evaluating the current Parent Infant Network vendor ability to meet objectives and outcomes and expand from the pilot phase to implementation phase.

2. Continued to monitor the Parent Information Network grant which was to make resouces available on various conditiosn including the risks of low birth weight and high risk births like that lead to a child born with a disability.

3. Continued the Epilepsy program that provides eduacation to parents about epilepsy and high risk deliveries. The Epilepsy Foundation also established a partnership with the District's managed care organizations to ensure children suffering from epilepsy and seizure disorders receive coordinated care within a medical home. The MCOs provide care coordination, support group meetings, educational sessions and mailings, service satisfaction/needs assessment, phone surveys, community forums, and support for children and youth to attend camps during the

summer.

c. Plan for the Coming Year

1. Guide the Parent Infant Network vendor to expand from the pilot phase to implementation phase. The scope of work will include expansion of navigation services to families with children with special needs; help desk, or resource directory of state and regional services for children with special health care needs, etc.

2) Award a subgrant to increase capacity of parents of children who were born with a disability (which can occur to low birth weight babies) to identify and access relevant resources to help the child.

3) Continue collaboration with APRA is important because women who are exposed to drugs, alcohol, and cigarettes during pregnancy are more likely to have low or very low birthweight babies.

4) Continue collaborations to identify mothers who need WIC services is important because mothers of lower socioeconomic status are more likely to have poorer pregnancy nutrition, inadequate prenatal care, and pregnancy complications.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	91.5	75	77	78	78
Annual Indicator	77.4	77.0	75.0	73.0	73.0
Numerator	5453	5409	5503	5642	5642
Denominator	7048	7025	7339	7731	7731
Data Source					2007 DC Birth File (Vital Statistics)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	80	80	80

Notes - 2008

There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007

The percent of infants born to women receiving prenatal care in the first trimester decreased from 75 percent in 2006 to 73 percent in 2007, a decrease of 2.6 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator reflects the number of women that reported recieving prenatal care in the first trimester.

The denominator reflects the number of District women that indicated when their prenatal care began.

Notes - 2006
Data will be updated when final 2006 data is available.

a. Last Year's Accomplishments
1. Continued to increase oversight and effectiveness of the Healthy Start program's nurse case management component.

2. Expanded recruitment, training and deployment of new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

3. Designed and launched "I am a Healthy DC Mom", a public information campaign.

4. Collaborated with DC Jails and shelters to increase early identification of pregnancy and ensure timely enrollment in prenatal care (PNC) for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

5. Collaborated with DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.

6. Collaborated with HAA to expand routine prenatal HIV testing and treatment to prevent perinatal HIV transmission to the infant.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Start case management services	X			
2. Family Support workers in Wards 5,6, 7, 8	X			
3. Health Start Conference convened to discuss healthier outcomes and strategies			X	
4. Outreach programs to pregnant women living in shelters	X			
5. Outreach programs to pregnant women incarcerated in DC Jail	X			
6. Public Health Campaign - " I am a Healthy DC Mom" - discusses issues to keep mom and baby healthy	X		X	
7.				
8.				
9.				
10.				

b. Current Activities

1. Continues to increase oversight and effectiveness of the Healthy Start program's nurse case management to encourage PNC in subsequent births .

2. Continues to recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

3. Continues to implement the public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy.

4. Continues early identification of pregnancy and ensure timely enrollment in PNC for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

5. Collaborates with DCHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.

6. Continues efforts with HAA to promote routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.

7. Enhancing linkage to mental health and substance abuse education and treatment services, to increase the number.

c. Plan for the Coming Year

1. Evaluate the effectiveness of the Healthy Start program's nurse case management component.

2. Continue to recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

3. Continue the public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy.

4. Continue the early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

5. Continue to collaborate with DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.

6. Continue to collaborate with HAA to ensure routine prenatal HIV testing and treatment.

7. Continue to collaborate with DMH and APRA to refer pregnant women and families to mental health and substance abuse education and treatment services, to ensure PNC is included in services.

8. Continue to collaborate with shelters to facilitate outreach and linkages to care for homeless pregnant women who may not receive PNC early.

9. Continue to support and participate in the Perinatal and Infant Health Advisory Group to identify and compile best practices based on existing data regarding infant mortality and perinatal

outcome disparities.

D. State Performance Measures

State Performance Measure 2: *Percent of Medicaid enrolles receiving EPSDT screening*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	75	75	78	78
Annual Indicator	71.3	76.8	77.4	73.6	70.2
Numerator	49951	54062	53636	52259	52289
Denominator	70102	70427	69320	71013	74441
Data Source					Medicaid Form 416
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	80	80	80

Notes - 2008
Data taken from the 2008 Medicaid 416 annual report.

Numerator is taken from Row 8: Total eligible who should receive at least one initial or periodic screen.

The denominator is taken from Row 9: Total eligible receiving at least one initial or periodic screen.

DC and MAA are collaborating on the EPSDT well child registry and this should help achieve the annual performance objective.

Notes - 2007
Data obtained from national Medicaid Report Form 416: Annual EPSDT Particpation Report.

Numbrator is row 8: Total eligibile who should receive at least one initial or periodic screen.

The denominator is row 9: Total eligible receiving at least one initial or periodic screen.

DC and MAA are collaborating on the EPSDT well child registry and this should help achieve the annual performance objectivel.

Notes - 2006
Form 416 FY06 Annual EPSDT Participation Report provided by the Medical Assistance Administration

a. Last Year's Accomplishments
The CASH Bureau continued:
1) to provide comprehensive age appropriate health care and health education to students in DCPS and Charter schools
2) oversight of the school nurse program including identification of additional health education programs that will promote healthy life styles.

The Perinatal and Infant Health Bureaus continued its work with sister Bureaus and DHCF to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, including the first two visits at 48 hours and 1 month post-discharge with the participating managed care organizations (MCO) and expansion of the Family Support Worker program.

Data collection from Shaw Junior High School Hearing and Vision Center will be utilized to support the District's success in meeting national and state performance requirements related to EPDST reporting requirements and special health care needs.

Schools and parents were informed of significant changes in immunization requirements for school age and younger children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide health education in school settings to students		X	X	
2. Provide school nurse program			X	X
3. Family support worker program	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The percent of Medicaid enrollees has been decreasing from 2006 to 2008.

1. Continued Bureau inter and intra agency collaborations to promote well child assessments.

2. Developed and distributed new immunization requirements to parents and schools and child development programs.

3. Continued oversight of school nurse program.

c. Plan for the Coming Year
1. Continue Bureau inter and intra agency collaborations to promote well child assessments.

2. Monitor and support implementation and complinace with new immunization requirements for school age and child development programs.

3. Continue oversight of school nurse program.

State Performance Measure 3: *Prevalence of lead levels > 10 ug/dL among chldren through age 6*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	**2004**	**2005**	**2006**	**2007**	**2008**

Performance Data					
Annual Performance Objective	2.2	1.9	1.9	1.9	1.9
Annual Indicator	1.3	1.3	1.8	1.3	0.6
Numerator	329	200	294	178	81
Denominator	26311	15121	15958	13851	13653
Data Source					DC 2008 Lead Trax Database
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.9	1.5	1.5	1.5	1.5

Notes - 2008
2008 Data is obtained from the Lead Trax information system. Currently there is a continued decrease in the number of children with elevated lead blood levels.

Notes - 2007
Data is obtained from the Lead Trax information system.
The numerator reflects the number of children <6 with elevated lead levels > 10 ug/dL .

The denominator is the total number of children < 6 screened.

Notes - 2006
Source: Information taken from the program's LeadTrax system.

a. Last Year's Accomplishments
1) DDOE Lead Program has flexibility to follow up and send an inspector to look for lead hazards. The draft notice of violation and lead poison hazard is sent to DDOE and the follow-up is conducted. A report is then sent to DCRA and the landlord or owner is notified. DCRA followed up with compliance.

2) DOH Bureau Collaborations - the Lead Safe DC (National Nursing Centers Consortium) receives referrals and briefs the client thru one on one education. Dust is elevaluated and if the home is positive they return and clean using specialized equipment

3) CFSA - refers properties to DDOE that will serve a child (on an emergency basis). The house must be safe from lead dust. The exception is if the child is placed with a family member.

4) AARA is funding a weatherization and energy program to replacement of doors and windows to decrease lead dust.

5) School Nurses -- submits to DDOE the health form if the lead test question is blank.

6) Lead Mobile Van is serving the Asian community

7) DC lead legislations --
- Defined lead based paint hazard definition. Included any peeling in a pre 1978 structure it assumes it is lead based hazard. Visual -- soil and dust soil. Issues a report
- Enforcement and inspections -- broad leeway given to DDOE.
- Follow-up on any positive homes
- Sept 2009 plan. A rental property will have to provide incoming tenants a clearance report that the home is free of lead contaminants. Phase 1 will focus on pregnant women and child under 6 years of age. If currently in a unit then you can request a clearance from the owner.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Policy requirement all labs must report Lead testing to DOH			X	
2. Perinatal and Inant Health Bureau refers pregnant women for environmental evaluation for dust and lead	X			
3. Stimulus funds will support weatherization and energy – replacement of doors and windows for meet eligibility to decrease lead dust.	X			
4. Lead Mobile Van - community visits to evaluate for lead.	X			
5. DC passed first comprehensive legislation to mitigate lead problems, including requirement that landlords and owners must provide documentation of alead free home.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
2008 data is obtained from the Lead Trax information system. Currently there is a continued decrease in the number of children with elevated lead blood levels since 2006.

1) DDOE Lead Program has flexibility to follow up and send in inspector to look for lead hazard. The draft notice of violation and lead poison hazard is sent to DDOE and the follow-up is conducted. A report is then sent to DCRA and the landlord or owner is notified. DCRA followed up with compliance.

2) DOH Bureau Collaborations - the Lead Safe DC (National Nursing Centers Consortium) receives referrals and briefs the client, one on one education. Dust is elevaluated and if positive they return and clean using specialized equipment

3) CFSA - refers properties that will serve a child (on an emergency basis). House must be safe from lead dust. The exception is if the child is placed with a family member.

4) AARA is funding a weatherization and energy program to replacement of doors and windows to decrease lead dust.

5) School Nurses -- submit health form if the lead test question is blank.

6) Continued Lead Mobile Van in the Asian community

c. Plan for the Coming Year
1) Continue follow-ups for lead violation referrals

2) Continue DOH Bureau Collaborations - the Lead Safe DC (National Nursing Centers Consortium) receives referrals and brief the client. Continue dust elevaluation and if positive they return and clean using specialized equipment

3) Continue CFSA collaboration to evaluate any home for placed children

4) Distribution funding for weatherization and energy program to replace doors and windows to

decrease lead dust.

5) Conduct follow-up from school health form if the lead test question is blank.

6) Continue Lead Mobile Van in underserved communities

State Performance Measure 4: *Prevalence of tobacco use among pregnant women*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	1.9	1.7	1.7	1.7	1.7
Annual Indicator	3.4	4.3	3.7	3.5	3.5
Numerator	270	340	315	306	306
Denominator	7918	7940	8522	8869	8869
Data Source					2007 DC Birth File (Vital Statistics)
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.7	2.5	2.5	2.5	2

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Note: The change in the 2013 performance objective reduction from 2.5 to 2.0 the continuing trend is that less women are smoking during their pregnancy. Efforts are also underway within DOH programs such as Healthy Start and community based organizations to encourage pregnant/parenting mothers to cease and quit smoking.

Notes - 2007
The prevalence of tobacco use among pregnant women decreased from 3.7 percent in 2006 to 3.4 percent in 2007, a decrease of 5.4 percent.

Source: District of Columbia State Center for Health Statistics 2007 Birth file.

Numerator: The number of women who self reported smoking during pregnancy.

Demominator: Out of the 8,870 live births, only 8869 women answered the question about smoking during their pregnancy for the birth certificate.

Notes - 2006
Data will be updated when final data for 2006 is available.

a. Last Year's Accomplishments
The CASH Bureau will continue to provide comprehensive age appropriate health care and health education to students in a school setting; continue oversight of the school nurse program including identification of additional health education programs that will promote healthy life styles. Plans also include evaluation of the nutrition program and implement a data collection and evaluation system.

The Perinatal and Infant Health Bureaus will continue to work with sister Bureaus to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, including the first two visits at 48 hours and 1 month post-discharge with the participating managed care

organizations (MCO) and implementation of the Family Support Worker program.

Data collection from Shaw Junior High School Hearing and Vision Center will be utilized to support the District's success in meeting national and state performance requirements related to EPDST reporting requirements and special health care needs.

Rewrote regulations to the Universal Health Certificate requiring annual physicals prior to attending school.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prenatal case management services educate pregnant women on hazards of smoking	X			
2. New 2009 DC Birth certificate captures information on alchol and smoking use		X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CHA staff continues to collaborate with DHCF

The Perinatal and Infant Health Bureaus continued to work with sister Bureaus to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge with the participating managed care organizations (MCO)

The CASH Bureau continues to provide comprehensive age appropriate health care and health education to students in a school setting; continue oversight of the school nurse program including identification of additional health education programs that will promote healthy life styles., including the effects of smoking during pregnancy and early childhood.

A new survery question was added to the birth certificate asking new moms about smoking habits during pregnancy. It will be self reported data.

c. Plan for the Coming Year
The activities for the coming grant year include:

1) Continue education through Healthy Start and Family Support Workers programs as well as through PIHB media campaign.
2) Continue and promote expansion of Health and Sexuality Education programs in DCPS and

Charter Schools
3) Collaborate with DCPS to assist in its development and implementation of Health and Sexuality Education courses in all District schools.

State Performance Measure 6: *Percent of resident women who give birth with no prenatal care or entry into prenatal care in 3rd trimester*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.8	5.4	5.3	5	5
Annual Indicator	6.4	5.6	6.4	6.4	6.4
Numerator	453	392	471	494	494
Denominator	7048	7025	7339	7731	7731
Data Source					2007 DC Birth File (Vital Statistics)
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5	5	5	5	5

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File. The numerator reflects the number of District women who self reported recieving prenatal care (PNC) in the third trimester or no PNC during their pregnancy.

The percent of resident women who give birth with no prenatal care or prenatal care in the third trimester decreased from 6.4 percent in 2006 to 5.6 percent in 2007, a decrease of 12.5 percent.

Note out of 8,870 live births, the denominator reflects the number of women (n=7728) that reported beginning prenatal care in the 3rd trimester or no prenatal care at all.

Notes - 2006
Data will be updated when final 2006 birth file becomes available.

a. Last Year's Accomplishments
Note:The percent of resident women who give birth with no prenatal care or prenatal care in the third trimester decreased from 6.4 percent in 2006 to 5.6 percent in 2007, a decrease of 12.5 percent.

1) The Community Health Administration partnered with sister administrations within DOH and other government agencies to ensure that screening and identification of at-risk families is widespread to increase enrollment in prenatal care and home visitation programs. Specifically, Healthy Start's nurse case managers and family support workers will link high-risk women to needed care provided by sister agencies, including tobacco cessation, substance abuse treatment, HIV screening and care, and other services. For example, collaboration with DC Jail to identify and support incarcerated pregnant women as well as homeless pregnant women and new moms living in shelters. Also working with schools to support prenant teens who are either in or out of school.

2) Increased the capacity of home visits and impact of the DOH home visitation program for pregnancy and postpartum pregnant women and their children. These home visitation programs promote a healthier physical and social environment in the home and link families to needed care.

3) Expanded the family support worker program is to increase the capacity and impact of the DOH home visitation program for pregnancy and postpartumpregnant women and their children. The result was 800 visits by December 2008.

4) Continued the Data Integration Project to link Kids Indirect application

5) Continued the MOM unit that provides prenatal services and linkages to prenatal care and access to services and entitlements.

6) Continued to provide transportation to services for uninsured pregnant women

7) Continued to coordinate outreach with DHCFs managed care contracts

8) Convened and expanded the Perinatal Advisory Group to a second year. Named two co-chairpersons and established two sub commmittees. A component of the Advisory Board charter is to conduct meaningful and comprehensive evaluation of Healthy Start and other existing parenting oriented programs in DC. The goal seeks to optimize parenting services offered , incorporating systemic assessment of pychosocial and behavioral risk and protective factors as a part of perinatal, infant and prenatal and intraconceptual pratice.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Case management services	X	X		
2. Collaboration with WIC in 14 IMA facilities	X			
3. Family support workers	X			
4. Collaboration with DC Jails and shelters			X	X
5. Collaboration with school nurse program to support pregnant teens	X		X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) Oversight of the Healthy Start Program as well as the Infant Mortality Action Plan.
2) Implemented three strategies for improvement in perinatal and infant care over the course of the next year.
3) Other activities include but are not limited to:
- Healthy Start case managers and family support worker program
- Data Integration Project to link Kids Indirect application
- MOM unit to provide prenatal services and linkages to care
- Provide transportation to services for uninsured pregnant women
- Coordinate outreach with MAA's managed care contracts
- Participate in Perinatal Advisory Group including sub group activities
- Monitoring the impact of the public media campaign

c. Plan for the Coming Year
1) Continue oversight of the Healthy Start Program as well as the Infant Mortality Action Plan.
2) Continue to implement and evaluate strategies for improvement in perinatal and infant care over the course of the next year.
3) Continue Data Integration Project to link Kids Indirect application
4) Evaluate effectiveness of MOM unit to provide prenatal services and linkages to care
5) Continue to Provide transportation to services for uninsured pregnant women
6) Continue to coordinate outreach with MAA's managed care contracts
7) Continue to support and participate in the Advisory Group including sub group activities
8) Expand and monitor the impact of the public media campaign

State Performance Measure 7: *Incidence of repeat births for teens less than 19 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	19.6	19.3	19	18.5	18.5
Annual Indicator	16.8	14.0	12.1	12.5	12.5
Numerator	95	81	84	89	89
Denominator	566	580	693	713	713
Data Source					2007 DC Birth File (Vital Statistics)
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18.5	18.5	18	18	17.5

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

PERFORMANCE MEASURE: The reduction in 2013 to 17.5 from 18 reflects the Districts intent to continue to reduce teen age pregnancy among District adolescent girls.

Notes - 2007
The incidence of repeat teen births for teens less than 19 years of age increased from 12.1 percent in 2006 to 12.5 percent in 2007, an increase of 3.3 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Notes - 2006
2006 birth file .

a. Last Year's Accomplishments
Note:The incidence of repeat teen births for teens less than 19 years of age increased from 12.1 percent in 2006 to 12.5 percent in 2007, an increase of 3.3 percent.

1) Continues to provide Health and Sexuality Education Program including: health and sexuality education, comprehensive health services, and pregnancy prevention programs.

2) CHA CASH Bureau continued its oversight and collaboration with school nurses to provide

health education services in the DC Public Schools and Charter Schools.

3) PIHB collaborative activities: 1) early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance utilizing Healthy Start case managers and family support workers; 2) Expanded well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) conducted routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant; 4) Enhanced linkage to APRA and other community based substance abuse education and treatment services; 5) Enhanced community-based screening and prevention services for at risk families and youth served by child protective service agency; 6) Facilitated outreach and linkages to care for homeless pregnant women and living in shelters; 7) Improved screening practices for all women and youth at risk for mental illness; and 8) Worked with the Department of Corrections to provide adequate prenatal care for pregnant inmates during incarceration.

4) Continued the 1-800-MOM-BABY HEALTHLINE or 311 number to provideinformation about pregnancies. The automated call distribution software was adapted to permit the capture of calls related to maternal and child services and support the data collection requirements of the Title V Block Grant.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Subgrantees to offer "Girl Talk" and "Healthy Generations" programs for second pregnancy prevention programs	X		X	
2. Carerra Model to promote self efficacy in young girls	X		X	
3. MOM unit to provide prenatal services and linkages to services	X			
4. Collaboration with HAA and APRA for bidirectional services		X	X	
5. Child and Family Services Administration collaboration			X	X
6. Perinatal Advisory Board identifying strategies to address repeat births among teens			X	X
7.				
8.				
9.				
10.				

b. Current Activities

1) Conducted Health and Sexuality Education Programs at various DCPS and a few Charter Schools as well as the Woodson Adolescent Wellness Center continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.

2) CHA CASH Bureau continues its oversight, monitoring compliance and collaboration with school nurses to provide health education services in the DC Public Schools and selected Charter Schools.

3) The Perinatal and Infant Health Bureau activities include 1) increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under

Medicaid and the DC HealthCare Alliance; 2) Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant; 4) Enhance linkage to substance abuse education and treatment services; 5) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency; 6) Facilitate outreach and linkages to care for homeless pregnant women; 7) Improve screening practices for all women and youth at risk for mental illness; and 8) Provide adequate prenatal care for pregnant inmates during incarceration.

4) Provided oversight pf the subgrantee implementing the Carrera Model.

c. Plan for the Coming Year

1) Continue Health and Sexuality Education Programs at various DCPS and a few Charter Schools as well as the Woodson Adolescent Wellness Center continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.

2) Continue CHA CASH Bureau oversight, monitoring compliance and collaboration with school nurses to provide health education services in the DC Public Schools and selected Charter Schools.

3) Continue the Perinatal and Infant Health Bureau activities include 1) increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance; 2) Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant; 4) Enhance linkage to substance abuse education and treatment services; 5) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency; 6) Facilitate outreach and linkages to care for homeless pregnant women; 7) Improve screening practices for all women and youth at risk for mental illness; and 8) Provide adequate prenatal care for pregnant inmates during incarceration.

4) Monitor subgrantee implementing the Carrera Model.

State Performance Measure 8: *Percentage of high school students who were in a physical fight one or more times during the past 12 months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			33	30	28
Annual Indicator		36.3	36.3	43	43
Numerator					
Denominator					
Data Source					2007 YRBSS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	26	25	25	25	25

Notes - 2008
Source: 2007 YRBSS

Retrieved on April 3, 2009 from
http://apps.nccd.cdc.gov/yrbss/CompTableoneLoc.asp?X=1&Loc=DC&Year1=2007&Year2=2005

Notes - 2007
Source:
http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?ByVar=CI&cat=1&quest=Q20&loc=DC&year=2007 95% confidence interval.

Technical Assistance was requested to address Violence Prevention in DC.

Note; The YRBS is conducted in odd years.

Notes - 2006
Source: YRBS
http://apps.nccd.cdc.gov/yrbss/CompTableoneLoc.asp?X=1&Loc=DC&Year1=2005&Year2=2003
. 2003 Survey 95% confidence intervals 38%± 3.2; 2005 Survey 36.3% ± 2.5

a. Last Year's Accomplishments
1) Implemented a school health plan that includes school violence prevention programs at selected schools with a high incidence of youth violence in collaboration with DCPS.

2) Collaborated with DC Public Schools nurse program to monitor the screening and referral systems for mental health and other issues that may lead to school violence. Full service middle school wellness teams detect behavioral problems and address them before they become clinically significant.

3) Contiued the Rape Prevention and Education (RPE) Program with other CHA components and several other DC DOH administrations to provide sexual violence and dating violence prevention in DC Public Schools.

4) Continued to analyze the appropriate policy and programs that address rate of deaths due to violence and injury.

5) Continued to evaluate the best practices to mitigate youth violence and injury among District middle and high school students.

6) Continued to analyze the appropriate policy and programs that address rate of deaths due to violence and injury and develop strategies to mitigate physical fights in schools and neighborhoods.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Granted funds to the Edgewood/Brookland Collaborative for violence prevention programs.			X	X
2. Metropolitan Police Department applied for fund to provide services for court involved youth through AARA funding		X	X	X
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
1) Working with DC Public Schools along with other youth-related programs continued to implement a school health plan strategies that includes school violence prevention programs at selected schools with a high incidence of youth violence.

2) Collaborating with DC Public Schools nurse program to monitor the screening and referral systems for mental health and other issues that may lead to school violence. Full service middle school wellness teams detect behavioral problems and address them before they become clinically significant.

3) Continuing tThe Rape Prevention and Education (RPE) Program with other CHA components and several other DC DOH administrations to provide sexual violence and dating violence prevention in DC Public Schools.

4) Analyzing the appropriate policy and programs that address rate of deaths due to violence and injury.

5) Evaluating in collaboration with community based organizations and youth justice system the best practices to mitigate youth violence and injury among District middle and high school students.

6) Continuing to analyze the appropriate policy and programs that address rate of deaths due to violence and injury and develop strategies to mitigate physical fights in schools and neighborhoods.

c. Plan for the Coming Year
The plans for the 2010 grant year include but are not limited to:

State Performance Measure 9: *Percent of preterm births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12	11.5	11
Annual Indicator	12.5	12.5	13.4	12.2	12.2
Numerator	980	989	1135	1076	1076
Denominator	7869	7897	8464	8818	8818
Data Source					2007 DC Birth File (Vital Statistics)
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.5	10	10	10	10

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007

The percent of pre term births decreased from 13.4 percent in 2006 to 12.2 percent in 2006, a decrease of 8.9 percent.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator (n=1076) is the number of births < 37 weeks gestation.

The denominator (n=8818) of live birth excludes the missing data n=52.

Notes - 2006
Data will be updated when final 2006 birth file data becomes available.

a. Last Year's Accomplishments
The percent of pre term births decreased from 13.4 percent in 2006 to 12.2 percent in 2006, a decrease of 8.9 percent.

1) DOH continues a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. CHA will be collaborating with a number of programs to assess the various data that are captured for inclusion in trend analysis. In addition, CHA will be developing a database on infant birth, morbidity and mortality statistics for the State to assist programs with planning and services.

2) Increase coordination with DC Jails and shelters expand a comprehensive, citywide approach to reducing infant mortality.

3) Convened a Healthy Start Conference to strengthen its partnership with healthcare providers, community-based organizations, and patient advocacy groups to identify opportunities for collaboration and mutual support in the effort to prevent mortality, lifelong disabling conditions, and other threats to infant health.

4) Expanded the Family Support Worker Program to improve discharge planning and linkage to appropriate medical and social services for women admitted to birthing hospitals with inadequate prenatal care and at risk for domestic violence, substance abuse or other factors that negatively affect infant development;

5) Developed a public information campaign, "I am a Healthy DC Mom" which was vetted in the community

6) Continues the advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities. Membership includes DOH and National Institute of Child Health and Human Development (NICHD), health care providers, managed care companies, and community-based organizations; and 4) Commission a comprehensive study of factors associated with infant death and developmental disability for Medicaid beneficiaries in the District of Columbia and identify novel population-based preventive activities

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Health Start Program and Home Visitation Program	X		X	

2. Family Support Worker Program	X			
3. Collaborations with various DC agencies: DC Jail, shelters, CFSA			X	X
4. School nurse program to support pregnant teens	X		X	
5. Public Information Campaign - I am a Healthy DC Mom		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Epideminology continues a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality.

2) Continues coordination with DC Jails and shelters to identify pregnant women and refer to services and entitlements in efforts to reduce infant mortality.

3) Continue the Family Support Worker Program to improve discharge planning and linkage to appropriate medical and social services for women admitted to birthing hospitals with inadequate prenatal care and at risk for domestic violence, substance abuse or other factors that negatively affect infant development;

5) Launch and continue the public information campaign " I am a Healthy Mom"

6) Continues to support and participate in the advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome dispariti

c. Plan for the Coming Year

1. Develop Request for Proposal solicit a vendor to conduct the PRAMS Survey for the Maternal Child Program. and individual health care interventions that will reduce infant mortality.

2. Develop an evalution of the Healthy Start program and at the same time develop program outcomes.

3. Continue trend analysis of infant mortality

4. Continue the public information campaign I am a Healthy DC Healthy Mom and evaluate short term success

E. Health Status Indicators

Introduction

/2010/ The Safe Passages Information System (SPIS), developed by the Office of Chief Technologies Officer (OCTO) placed their information systems onto SPIS platform.

DC Vital Records provides more accurate and comprehensive reporting of data collected delievery including alcohol and smoking use during pregnancy.

The DC Primary Care Association is developing the DC Regional Health Information

Organization (DC RHIO) enabling data sharing between hospitals and community based health centers, allowing realtime viewing of health patient information stored in a central location.

Medical Homes Project - Development of a coordinated, integrated system of health care for children and youth with special health care needs (CYSHCN). Medical Homes Pilot to utilize parent navigators to help other families navigate the healthcare system; implementing learning collaborative sessions to familiarize other providers with the medical homes concept and establishing a medical home-parent advisory council.

Destination Known: Making Health Care Transition Happen for YSHCN in DC who are transitioning from pediatric care into adult care. This initiative will identify best practice models for transition case management.

Overweight and Obesity Prevention Reducation Action Plan will be published Fall 2009. Developed by a consumer and provider and interagency collaborative. More than 200 stakeholders from Wards 8, 5 and 4 as well as Latino and youth groups attended six stakeholder meetings. //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	11.1	8.5	9.0	11.1	11.1
Numerator	877	674	769	989	989
Denominator	7919	7940	8522	8870	8870
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The denominator: Out of the 8870 live births, only 8862 had birthweights recorded, and 8 infants w/o recorded birthweights. Those eight were coded as 9999 for missing.

Notes - 2006
Data will be updated when final 2006 birth file becomes available.

Narrative:
/2010/ The is no change in the statistics from the previous year. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and

collaboration with District agencies such as DC Jails, shelters and Child and Family Services Administrators.

Other efforts include:
1) the development and launch of the public information campaign DC Healthy Mom focused on keeping babies safe, including parenting, wellness and screening requirements.

2) collaboration with the newly named Department of Health Care Financing (DHCF) to promote well child visits.

3) promotion and implementation of "Girl Talk" and "Healthy Generations" as well as Carerra Model to address and mitigate teen pregnancies, including rapid second pregnancies in teens. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.3	7.0	7.7	9.3	9.3
Numerator	710	535	635	796	796
Denominator	7633	7636	8198	8543	8543
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The numerator reflects that n=796 live singleton births weighing <2,500 grams.

The denominator (n=8543) accounts for the number of live singleton births.

Notes - 2006
Data will be updated when final 2006 birth file becomes available.

Narrative:
/2010/ The is no change in the statistics from the previous year. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and collaboration with District agencies such as DC Jails, shelters and Child and Family

Services Administrators.

Other efforts include:
1) the development and launch of the public information campaign DC Healthy Mom focused on keeping babies safe, including parenting, wellness and screening requirements.

2) collaboration with the newly named Department of Health Care Financing (DHCF) to promote well child visits.

3) promotion and implementation of "Girl Talk" and "Healthy Generations" as well as Carerra Model to address and mitigate teen pregnancies, including rapid second pregnancies in teens. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2.8	2.7	2.5	2.9	2.9
Numerator	220	214	217	258	258
Denominator	7919	7940	8522	8870	8870
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The denominator: Out of the 8870 live births, only 8862 had birthweights recorded, leave 8 infants w/o recorded birthweights. Those eight were coded as 9999 for missing.

Notes - 2006
Data will be updated when final 2006 birth file becomes available.

Narrative:
/2010/ The percent for low birth weight births increased slightly fron 2.5 in 2006, to 2.9 in 2007. Please note that 2008 data will be available in 2010. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and collaboration with District agencies such as DC Jails, shelters and Child and Family Services Administrators.

Other efforts include:
1) the development and launch of the public information campaign DC Healthy Mom

focused on keeping babies safe, including parenting, wellness and screening requirements.

2) collaboration with the newly named Department of Health Care Financing (DHCF) to promote well child visits.

3) promotion and implementation of "Girl Talk" and "Healthy Generations" as well as Carerra Model to address and mitigate teen pregnancies, including rapid second pregnancies in teens. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2.3	2.1	2.0	2.3	2.3
Numerator	179	160	164	198	198
Denominator	7633	7636	8198	8537	8537
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
There is a 2-year lag period in the District for reporting birth and death data. Data for 2008 will be available in 2010. 2007 data is reported here.

Notes - 2007
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

The denominator (n=8537) accounts for the number of live singleton births. There were 2 births coded as 9999 were "missing" birthweights for 2 singelton deliveries.

Notes - 2006
Data will be updated when final 2006 birth data becomes available.

Narrative:
/2010/ The percent of live singleton births from 2006 to 2007 increased slightly by 0.8 percent. The Perinatal and Infant Health Bureau continues its Healthy Start case management and home visitation programs as well a Family Support Worker program to conduct outreach efforts to pregnant women. Outreach efforts include use of MOM van; staff co-located in WIC centers; and collaboration with District agencies such as DC Jails, shelters and Child and Family Services Administrators.

Other efforts include:
1) the development and launch of the public information campaign DC Healthy Mom focused on keeping babies safe, including parenting, wellness and screening requirements.

2) collaboration with the newly named Department of Health Care Financing (DHCF) to

promote well child visits.

3) promotion and implementation of "Girl Talk" and "Healthy Generations" as well as Carerra Model to address and mitigate teen pregnancies, including rapid second pregnancies in teens. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.4	6.2	6.3	7.4	7.4
Numerator	6	6	6	7	7
Denominator	93747	96217	95176	93980	93980
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008
The District of Columbia has a 2-year delay for reporting death data. Currently 2007 death data is used to populate information for 2008. When data becomes available, this measure will be updated.

Source: Numerator: The District of Columbia, State Center For Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2007
Source: Numerator: The District of Columbia, State Center For Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2006
2005 data not available at the time of this report. Numerator reflects the 2004 data and is therefore an estimate. When data becomes available it will be updated.

Denominator: Source Table 2. estimates of the Population by Sex and Age for the District of Columbia: April 1, 2000 to July 1, 2005. (SC-EST2005-02-11) Population Division, US Census Bureau

Narrative:
/2010/ Currently, this measure yields low numbers of unintentional injuries among children. There was an additional death from 2006 to 2007. District Agencies applied for more than $5 Million in AARA or Stimulus Grants for Crime Control, Youth Violence Prevention, Victim Assistance

The Metropolitan Police Department (MPD) and Department of Youth Rehabilitation Services (DYRS) have submitted six applications to the US Department of Justice funding under the American Recovery and Reinvestment Act for a number of high-priority law enforcement and juvenile justice related projects. The applications, which requested funding in excess of $5 million, include:

1) Support for TEAM-DC, a Local-Federal Law Enforcement Task Force to Combat Violent Crime
Lead Agency: Metropolitan Police Department
Project Focus: Staffing and technology enhancements for "TEAM-DC," an innovative antiviolence initiative being used to reduce crime in the District's most at-risk communities. The funding request includes interview and interrogation training, cell phone tracking technology, and additional crime trend analysis.

2) Increased Supervision and Support for Court-Involved Youth Residing in the Community
Lead Agency: Department of Youth Rehabilitation Services
Project Focus: Reducing case manager-to-youth ratio for supervision of highest-need young offenders, to include intensive oversight and management of supportive services, frequent contacts with family, school, etc., and increased engagement with community groups.

DOH convened the Englewood and Brookland Collaborative to address youth violence. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2.1	0.0	4.2	3.2	3.2
Numerator	2	0	4	3	3
Denominator	93747	96217	95176	93980	93980
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The District of Columbia has a 2-year delay for reporting death data. Currently 2007 death data is used to populate information for 2008. When data becomes available, this measure will be updated.

Source: Numerator: The District of Columbia, State Center For Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2007
Source: Numerator: The District of Columbia, State Center For Health Statistics 2007 Death File. The numerator is correct as there were only 3 deaths attributed to motor vehicle crashes.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html
.

Notes - 2006
The numerator was determined from ICD 10 codes (V20 - V89). Data will be updated when final 2006 data becomes available.

Narrative:
/2010/ Currently, this measure yields low numbers of unintnentional injuries due to motor vehicle accidents among children. There was an additional death from 2006 to 2007. DOH continues it collaborative efforts to evaluate policies that impact children aged 14 years and younger with injuries due to motor vehicles crashes. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	11.6	2.2	2.2	4.3	4.3
Numerator	9	2	2	4	4
Denominator	77387	90414	92860	93448	93448
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The District of Columbia has a 2-year delay for reporting death data. Currently 2007 death data is used to populate information for 2008. When data becomes available, this measure will be updated.

Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2007
Source: Numerator: The District of Columbia, State Center for Health Statistics 2007 Death File.

Denominator: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia. http://www.census.gov/popest/states/asrh/SC-EST2007-02.html

Notes - 2006
Data will be updated when final 2006 data becomes available.

Denominator: Source Annual Estimates of the Population by Age and Sex for District of Columbia: April 1, 2000 to July 1, 2006. US Census Bureau

Narrative:
/2010/ Currently, this measure yields low numbers of unintentional injuries due to motor vehicle crashes among youth 15-24 years. Although this measure increased from 2 deaths in 2006 to 4 deaths in 2007. Numbers remain extremely small and statistical comparisions are not applicable. The DOH continues to conduct an analysis of policies that impact youth aged 15-24 years with injuries due to motor vehicle crashes. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5,579.9				
Numerator	5231			0	0
Denominator	93747				
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
The District does not have an injury surveillance system. No estimates are available for 2008.

Notes - 2007
The District does not have an injury surveillance system. No estimates are available for 2007.

Notes - 2006
The District does collect any injury surveillance data.

Narrative:
/2010/ No data reported as the District does not have an injury surveillance system in place. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	64				
Numerator				0	0
Denominator					
Check this box if you cannot report the			Yes	Yes	Yes

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
The District does not have an injury surveillance system. No estimates are available for 2008.

Notes - 2007
The District does not have an injury surveillance system. No estimates are available for 2007.

Notes - 2006
DC does not have an injury surveillance system in place. There is not sufficient information to provide an estimate.

Narrative:
/2010/ No data reported as the District does not have an injury surveillance system in place. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	155.1				
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
The District does not have an injury surveillance system. No estimates are available for 2008.

Notes - 2007
The District does not have an injury surveillance system. No estimates are available for 2007.

Notes - 2006
The District does not have an injury surveillance system. There is not sufficient information to provide an estimate.

Narrative:
/2010/ No data reported as the District does not have an injury surveillance system in place. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	87.0	90.4	74.8	77.6	89.0
Numerator	1125	1170	1006	1639	1895
Denominator	12937	12937	13448	21115	21290
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Numerator: 2008 STD MIS data.

Denominator: Table 2: Annual Estimates of the Resident Population by Sex and Age for District of Columbia: April 1, 2000 to July 1, 2008 (SC-EST2008-02-11)

Notes - 2007
Numerator: Source 2007 District of Columbia STD disease report., generated by STD*MIS database.

Denominator: US Census 2005 population estimates.

Notes - 2006
The 2006 data will be entered when it becomes available.

Narrative:
/2010/ The rate of women aged 15 through 19 years with a reported case of Chlamydia increased from a rate of 77.6 , per 1,000 women in 2006 to a rate of 89.0 per 1,000 (in 2007, an increase of 15.6 percent. During the past two years the Department of Health as well as HAA have aggressively encouraged teens to participate in testing. In addition, CHA offers health and sexuality education, promoting the need for screening and impact of STDs. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	13.5	13.6	13.6	17.3	18.2
Numerator	1659	1674	1674	2136	2319
Denominator	123339	123339	123339	123339	127546
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source:
Denominator: 2008 STD MIS data.

Numerator; Table 2: Annual Estimates of the Resident Population by Sex and Age for District of Columbia: April 1, 2000 to July 1, 2008 (SC-EST2008-02-11)

Notes - 2006
This is 2005 data, used as an estimate. The 2006 data will be entered when it becomes available.

Narrative:
/2010/ The rate of women aged 20 through 24 years with a reported case of Chlamydia increased from a rate of 17.3, per 1,000 women in 2006 to a rate of 89.0 per 1,000 in 2007, an increase of 15.6 percent.DOH and HAA have conducted aggressive campaigns and outreach to increase awareness and testing of District residents for STDs. As a result there has been an increae in testing and reporting. DOH expects that the statistics may continue to rise as the under reporting issue is resolved. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	8870	2370	4926	3	87	125	0	1359
Children 1 through 4	32777	9825	20408	0	735	0	0	1809
Children 5 through 9	28285	6895	18398	0	970	0	0	2022
Children 10 through 14	27244	2577	21997	0	363	0	0	2307
Children 15 through 19	37633	10528	25197	0	775	0	0	1133
Children 20 through 24	50521	21885	23745	0	2162	0	0	2729
Children 0 through 24	185330	54080	114671	3	5092	125	0	11359

Notes - 2010
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables.
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex

by Age by race tables.
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables.
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables.
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables.
Retrieved on 04/17/2009 from www.census.gov

Narrative:
/2010/ District population statistics remain relatively unchanged from the previous reporting period. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	7354	1487	29
Children 1 through 4	2860	4176	0
Children 5 through 9	22594	2691	0
Children 10 through 14	24484	2760	0
Children 15 through 19	35044	2589	0
Children 20 through 24	45505	5016	0
Children 0 through 24	137841	18719	29

Notes - 2010
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables. B01001I. Sex by Age (Hispanic or Latino)
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables. B01001I. Sex by Age (Hispanic or Latino)
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex

by Age by race tables. B01001I. Sex by Age (Hispanic or Latino)
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables. B01001I. Sex by Age (Hispanic or Latino)
Retrieved on 04/17/2009 from www.census.gov

Source: United States Census Bureau.
Data Set: 2007 American Community Survey 1-year estimates for the District of Columbia -Sex by Age by race tables. B01001I. Sex by Age (Hispanic or Latino)
Retrieved on 04/17/2009 from www.census.gov

Narrative:
/2010/ There are no changes in demographics from previous reporting year//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	24	2	18	0	0	0	0	4
Women 15 through 17	393	8	318	0	0	0	0	67
Women 18 through 19	658	16	526	0	2	3	0	111
Women 20 through 34	5918	1312	3425	1	57	84	0	1039
Women 35 or older	1844	1026	620	1	27	37	0	133
Women of all ages	8837	2364	4907	2	86	124	0	1354

Notes - 2010
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Narrative:
/2010/ /2010// Because teen pregnancy statistics remain essentially unchanged from the previosu reporting period DOH has expanded programs to address teen sexual health and pregnancy. Through sub grant awards DOH supports programs such a "Girl Talk"

"Healthy Generations" and Carerra Model programs as well as staff conducting health and sexuality education programs in DC Public and Charter schools. //2010// //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	20	4	0
Women 15 through 17	323	70	0
Women 18 through 19	539	119	0
Women 20 through 34	4874	1134	0
Women 35 or older	1687	157	0
Women of all ages	7443	1484	0

Notes - 2010
Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Source: The District of Columbia State Center for Health Statistics 2007 Birth File.

Narrative:
/2010/ Statistics remain unchanged because the data is from 2007 reporting period. The live births in teens under 19 remain a primary focus of CHA to decrease the number of teen birth as well as rapid second pregnancies. Through sub grantee awards the "Girl Talk", "Healthy Generations" and Carrera Model Program seek to foster self esteem in girls and educate them in sexual health. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	116	26	84	0	0	0	1	5
Children 1 through 4	11	3	8	0	0	0	0	0
Children 5 through 9	9	2	7	0	0	0	0	0
Children 10	5	0	5	0	0	0	0	0

through 14								
Children 15 through 19	37	4	33	0	0	0	0	0
Children 20 through 24	56	6	50	0	0	0	0	0
Children 0 through 24	234	41	187	0	0	0	1	5

Notes - 2010
Source: District of Columbia 2007 Infant Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Narrative:
/2010/ Statistics are from previous reporting period and therefore do not reflect changes based on program enhanced or established to address infant and children deaths. Programs, such as Healthy Start, Family Support Workers as well as education in Sicle Cell Disease and other chrinic diseases continue to promote wellness and treatment strategies. CHA is seeking technical assistance to evaluate deaths in children and then develop strategies to mitigate death in infants and children. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	93	14	9
Children 1 through 4	11	0	0
Children 5 through 9	8	1	0
Children 10 through 14	5	0	0
Children 15 through 19	34	3	0
Children 20 through 24	54	1	0
Children 0 through 24	205	19	9

Notes - 2010
Source: District of Columbia 2007 Infant Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Source: District of Columbia, State Center for Health Statistics 2007 Death File.

Narrative:
/2010/ Statistics are from previous reporting period and therefore do not reflect changes based on program enhanced or established to address infant and children deaths. Programs, such as Healthy Start, Family Support Workers as well as education in Sicle Cell Disease and other chrinic diseases continue to promote wellness and treatment strategies. CHA is seeking technical assistance to evaluate deaths in children and then develop strategies to mitigate death in infants and children. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	100836	29825	60803	0	2937	0	0	7271	2007
Percent in household headed by single parent	60.0	0.0	0.0	0.0	0.0	0.0	0.0	60.0	2007
Percent in TANF (Grant) families	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Number enrolled in Medicaid	146523	0	0	0	0	0	0	146523	2008
Number enrolled in SCHIP	9350	0	0	0	0	0	0	9350	2008
Number living in foster home care	2255	0	0	0	0	0	0	2255	2008
Number enrolled in food stamp program	88203	0	0	0	0	0	0	88203	2008
Number enrolled in WIC	11543	247	10882	42	343	0	29	0	2007
Rate (per 100,000) of juvenile crime arrests	7.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade	86.0	1.0	84.0	0.0	1.0	0.0	0.0	0.0	2008

9 through 12)									

Notes - 2010
Source: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia.

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)
Single-parent families may include cohabiting couples and do not include children living with stepparents. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in this calculation.

Total TANF enrollment as of December 31, 2008. Data provided by the District of Columbia Health Care Policy and Planning Administration. Please note that SCHIp data is not curently available by race/ethnicity.

Total Medicaid enrollment as of December 31, 2008. Data provided by the District of Columbia Health Care Policy and Planning Administration. Please note that SCHIp data is not curently available by race/ethnicity.

Total SCHIP enrollment as of December 31, 2008. Data provided by the District of Columbia Health Care Policy and Planning Administration. Please note that SCHIp data is not curently available by race/ethnicity.

Source: Supplemental Nutrition Assistance Program: Number of Persons Participating by State-January 2009

URL: http://www.fns.usda.gov/pd/29SNAPcurrPP.htm
Accessed: May 6, 2009

Source: 2007 The Pregnancy Nutrition Surveillance System (PNSS) for the District of Columbia. This number reflects the 2007 enrollment for infants and children.

Source: Metropolitan Police Department
Washington, DC
Criminal Justice Information System (CJIS) Data
Queried Juvenile Arrest by Race and Ethnicity for CY 2008

Note: due to small numbers an numbers are used here.

Source for non-homicide arrest data: Criminal Justice Information System (CJIS) data as of 5/05/09. Totals are based solely on
the top arrest charge. One person may be booked on more than one arrest charge. Excludes arrests for which no location
could be identified (between 1 and 3% of all arrests).
Please note that changes to MPD's PSA and District boundaries occasionally occur. The

statistics above are based on current
police boundaries as of September 2, 2007.
[2]Source for homicide data: Homicide and Sexual Offenses Branch (HSOB) as of 5/05/09.
[3]For the purposes of the CJIS Arrest Report, the term "juvenile" used above is defined as individuals under the age of 18 years
(= 17 years of age). These "juvenile" totals may include Title 16 cases where juveniles are tried as adults.
The above non-homicide arrests reflect arrests made by all agencies in the District of Columbia.

Source: The District of Columbia Public Schools Student and Tracking Reporting System (STARS) 2007-2008. Please note that currently the STARS data system does not have the option, "more than one race" or "Hawaiian/Pacific Islander not separated out.

Source: District of Columbia- Child & Family Services Agency Yearly Caseload Report. Data not available by race/ethnicity

Narrative:
/2010/ Statistics are the same at 2009 because data is from 2007. The impact of current programs are unavailable at this time. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	100836	17232	0	2007
Percent in household headed by single parent	0.0	0.0	60.0	2007
Percent in TANF (Grant) families	0.0	0.0	5.0	2008
Number enrolled in Medicaid	0	0	146523	2008
Number enrolled in SCHIP	0	0	9530	2008
Number living in foster home care	0	0	2255	2008
Number enrolled in food stamp program	0	0	88203	2008
Number enrolled in WIC	15530	3987	0	2007
Rate (per 100,000) of juvenile crime arrests	7.5	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	86.0	13.0	0.0	2008

Notes - 2010
Source: United States Census Bureau. The 2007 American Community Survey Population Estimates for the District of Columbia.

The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2007 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full

implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)
Single-parent families may include cohabiting couples and do not include children living with stepparents. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in this calculation.

Total TANF enrollment as of December 31, 2008. Data provided by the District of Columbia Health Care Policy and Planning Administration. Please note that SCHIp data is not curently available by race/ethnicity

Total Medicaid enrollment as of December 31, 2008. Data provided by the District of Columbia Health Care Policy and Planning Administration. Please note that SCHIp data is not curently available by race/ethnicity

Total SCHIP enrollment as of December 31, 2008. Data provided by the District of Columbia Health Care Policy and Planning Administration. Please note that SCHIp data is not curently available by race/ethnicity

Source: Supplemental Nutrition Assistance Program: Number of Persons Participating by State-January 2009

URL: http://www.fns.usda.gov/pd/29SNAPcurrPP.htm
Accessed: May 6, 2009

Source: 2007 The Pregnancy Nutrition Surveillance System (PNSS) for the District of Columbia. This number reflects the 2007 enrollment for infants and children.

Source: Metropolitan Police Department
Washington, DC
Criminal Justice Information System (CJIS) Data
Queried Juvenile Arrest by Race and Ethnicity for CY 2008

Source for non-homicide arrest data: Criminal Justice Information System (CJIS) data as of 5/05/09. Totals are based solely on
the top arrest charge. One person may be booked on more than one arrest charge. Excludes arrests for which no location
could be identified (between 1 and 3% of all arrests).
Please note that changes to MPD's PSA and District boundaries occasionally occur. The statistics above are based on current
police boundaries as of September 2, 2007.
[2]Source for homicide data: Homicide and Sexual Offenses Branch (HSOB) as of 5/05/09.
[3]For the purposes of the CJIS Arrest Report, the term "juvenile" used above is defined as individuals under the age of 18 years
(= 17 years of age). These "juvenile" totals may include Title 16 cases where juveniles are tried as adults.
The above non-homicide arrests reflect arrests made by all agencies in the District of Columbia.

Source: The District of Columbia Public Schools Student and Tracking Reporting System (STARS) 2007-2008. Please note that currently the STARS data system does not have the option, "more than one race" or "Hawaiian/Pacific Islander not separated out.

Source: District of Columbia- Child & Family Services Agency Yearly Caseload Report. Data not available by race/ethnicity

Narrative:
/2010/ Statistics are the same at 2009 because data is from 2007. The impact of current programs are unavailable at this time. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	133544
Living in urban areas	134335
Living in rural areas	0
Living in frontier areas	0
Total - all children 0 through 19	134335

Notes - 2010
Source: District of Columbia Selected Demographic and Housing Estimates: 2007

Data set: 2007 American Community Survey 1-year estimates

Narrative:
/2010/ Statistics are the same at 2009 because data is from 2007. The impact of current programs are unavailable at this time. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	588292.0
Percent Below: 50% of poverty	8.6
100% of poverty	9.4
200% of poverty	15.6

Notes - 2010
Source: US Census Bureau
Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Source: US Census Bureau
Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Source: US Census Bureau
Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Source: US Census Bureau
Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Narrative:
/2010/ Statistics are the same at 2009 because data is from 2007. The impact of current programs are unavailable at this time. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	134335.0
Percent Below: 50% of poverty	14.2
100% of poverty	14.2
200% of poverty	21.8

Notes - 2010
Source: US Census Bureau

The Untied States Census Bureau, 2007 American Community Survey Population Estimates for the District of Columbia.
http://www.census.gov/popest/states/asrh/tables/SC-EST2007-02-11.xls

Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Source: US Census Bureau
Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Source: US Census Bureau
Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Source: US Census Bureau
Current Population Survey, (CPS) Annual Social and Economic Supplement, 2008

Data is taken from the 2007 CPS survey using the CPS table creator using for the Annual and Social Economic Supplement

Narrative:
/2010/ Statistics are the same at 2009 because data is from 2007. The impact of current programs are unavailable at this time. //2010//

F. Other Program Activities

Epilepsy
In 2004, MFHA received a federal grant, Awareness and Access to Care for Children and Youth with Epilepsy in the amount of $250,000.00 from 9/1/04-8/31/07 improve access to comprehensive, coordinated health care and related services for children and youth with epilepsy residing in MUAs by establishing links between families and MCOs while integrating community resources. DOH will subsidize family advocates at each of the four MCOss located in the DC. Caregivers will act as member-advocates, seeking and coordinating creative solutions to members' concerns. Year 1: community partnerships to allow early detection and treatment by improving access to ongoing care, addressing shortages in subspecialty care, identifying cultural and language barriers, and developing strategies for improving current systems of treatment. DOH anticipates the demonstration project will improve access to comprehensive, coordinated health care and related services for children and youth with epilepsy residing in MUAs throughout the District.

Vision Screening
The CSHCN staff and the Lions Club have conducted a vision screening program for several years, offering free screening for early detection of amblyopia in children from ages one to six years old. In addition to the screening at child care and pre-school facilities, vision screening was also conducted at many of the District's middle and junior high schools. Many uninsured or underinsured children do not have access to being fitted with eye glasses and this is a gap filling service. In FY 2005 1,526 children were screened with 358 referred for eye glasses. The work with the Lions Club is expected to continue in FY 2007 with screening to be focused on charter schools. Schools nurses conduct vision screening in conjunction with the contract with CNMC.

Physical Activity and Nutrition
In FY 2007, staff is planning to create, implement, support and enhance pilot initiatives in collaboration with community and government partners to address obesity and wellness amongst families, women, and men such as:

Worksite efforts supporting DOH employees to participate in regular on-site physical exercise in a minimum of two DOH building sites;

Support men and women by promoting wellness via increased exercise, improved nutrition, stress reduction, and routine check-ups;

Convene one to three community-based forums to solicit and encourage community involvement in the development of citywide programs to enhance nutrition and increase physical activity; and

Partner with community media supporting and encouraging residents to participate in exercise and other wellness activities, utilizing and expanding upon "lessons learned" from the 2005 "Listening4yourhealth" initiative with WPFW-Pacifica Radio.

/2008/ National Epilesy Foundation of America (NEFA) to ensure community-based service systems are organized so they can be used easily, and specifically to improve upon the health

system for children with epilepsy and/or seizure disorder. NEFA to establish a Metropolitan Chapter for Epilepsy in the District of Columbia.

The Nutrition and Physical Fitness Bureau (NPFB) has collaborated with DOH Communications, the former Adult and Family Services Bureau and WPFW-FM Pacifica Radio to develop a concept paper for a multi-year nutrition and fitness initiative entitled MOVE DC and will lead to a series of "Movement Clubs."

NPFB is proceeding with plans for a citywide conference on nutrition and fitness, "The Path to Wellness: A Lifelong Journey" to be held in 2007. In addition to being located in the community, this conference will engage community leaders and health activists both as participants and as presenters.

NPFB's Food Stamp Nutrition Education Program continues to provide nutrition and fitness classes to school children, parents and seniors using USDA's Team Nutrition curriculum. Meanwhile, NPFB has been an active participant with the Ward 8 Childhood Obesity Collaborative, working to support an initiative providing assistance and training on policy initiatives for expanding fresh food access this poor area of DC.

The Rape Prevention and Education Program (RPE) addresses violence toward and by children and youth in the District of Columbia. In addition, the RPE program targets universities and community members, because of the obvious maternal and child link with adult students/community members who (1) are survivors or of or at risk for sexual violence perpetration or victimization; and/or (2) have children who are survivors of or at risk for sexual violence perpetration or victimization.

Collaboration with the Lions Club for vision screening programs continues tjrpigj 2008 with a focus on charter schools. //2008//

/2009/ Other Program activities during this grant year included:

Perinatal and Infant Health Bureau convened an advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities.

Special Health Care Needs Bureau continued Lions Club activities; developed the Parent Information Network Request for Proposal.

The DC Child Health Action Plan focuses on Asthma including strategies to develop and implement quality improvement initiatives with DC medical providers to implement the Standardized asthma medical record form for use by primary care providers. //2009//

/2010/ CHA continue its 2009 Title V efforts.

Lead Program
With newly enacted comprehensive lead legislation, the DDOE Lead Program now is able to do much more than previously was possible, in particular performing proactive lead inspections in order to identify lead problems and have them remediated, prior to a child being exposed to lead. This new lead law also requires that rental property owners take proactive lead safety steps prior to renting their pre-1978 units to families containing either a pregnant woman or a child under the age of six. These "turnover requirements" are supplemented by additionally phased-in requirements over time, to eventually encompass all new occupants, not just those with pregnant women or young children. This makes the new DC lead law one of the most aggressive and innovative lead laws in the country. It expands DDOE responsibilities and provides leeway in enforcement and inspections.

The Lead Program activities for 2010 include:

1. ***Continue oversight of lead testing and data collection***
2. ***School nurse health form collaboration program***
3. ***Healthy Start program to evaluate homes***
4. ***Weatherization program***
5. ***Lead Mobile to needy communities, e.g. Asian and Latino***
6. ***Rental property inspections for lead-free property***

Family Voices of DC (FVDC) and CSHCN
CHA collaborates with Family Voices, an organization that is affiliated with the national Family Voices network whose mission is to "achieve family-centered care for all children and youth with special health care needs and or disabilities." Through its national network representing 50,000 families of children with special health care needs, and Family to Family agencies in fifty states and the District of Columbia, it provides families with tools to make informed decisions about services for their children, advocate for improved public and private policies, build partnerships among professionals and families and serve as a trusted resource for families on therapeutic and health care decisions. FVDC is integral in the CSHCN Advisory Board and a partner in the transition program with National Alliance to Advance Adolescent Health.

Oral Health
The CSHCN Oral Health Forum was held on May 22, 2007, from 8:30 am to 3:00 pm at the HSC Pediatric Center. The forum culminated in the development of recommendations and strategies for improving the oral health of CSHCN. Findings were generated around the issues of addressing barriers to oral health care to CSHCN as well as strategies for promoting the oral health of CSHCN. Final findings were included the overall DC Oral Health Plan. The final report and action plan will be posted on the CSHCN page of the ASTDD website.

Other oral health activities for 2010:
1) Development of a Policy to allow non-dental EPSDT health care providers to provide fluoride varnish.
2) Development of a Policy to allow Registered Dental Hygienists to provide dental hygiene services without the supervision of a dentist.
3) Development of a comprehensive State Oral Health Plan for the District of Columbia
4) Increase the visibility of the office through various networks: Howard Dental School, University of MD Dental School, local Dental Association, and HRSA. //2010//

An attachment is included in this section.

G. Technical Assistance

In the July 2005 grant application, MFHA described two technical assistance needs--one, for an analysis to ensure that any centralization and/or warehousing of surveillance functions in DOH results in the capability to generate and analyze data required for MCHB grant reporting, and, two, assistance from an MCH epidemiologist or health statistician experienced in working with mortality data to assist in the design of an analysis to identify trends in and contributing factors to mortality in the population aged 1 to 21. But MFHA did not follow up with a formal request to MCHB for technical assistance.

This year MFHA plans to request technical assistance to help with two issues. First, MFHA needs a CDC MCH epidemiologist for at least a one-year period to work with surveillance and data analysis staff to review, update and possibly design surveillance systems to enable the tracking

and analysis of data on infant mortality and morbidity. This level of assistance will provide analytic reports to inform planning to interventions to decrease infant mortality. Toward that end, the MFHA senior deputy director has initiated discussions with CDC and MCHB.

Second, MFHA needs assistance to organize a maternal and child health advisory committee. As described in the public input section of this application, MFHA has taken the initial step of gauging public interest in such a body. Now there is a need for a political scientist or a person knowledgeable about the development of civil society to assist with this effort.

During the grant review in August 2006, a third need was identified--assistance with file linkage, for example, in linking Medicaid eligibility and/or claims files with annual birth files.

/2008/ MPCA will seek technical assistance to explore the establishment of a MPCA Advisory Committee that may be composed of representation from existing advisory committees and other stakeholders. This committee will assist the Administration in identifying priorities and associated activities, allocating resources, identifying state performance measures, and monitoring progress. The primary role of the Committee will be to guide the Agency with appropriate information and guidance to meet the needs of mothers, infants, and children, including children with special health care needs; identify gaps in services within the District's health care delivery systems; and ensure that Title V funds are spent appropriately and support evidence-based programs that benefit families and improve the overall health of families within the District of Columbia. Technical assistance is being requested to help to establish the composition of the Committee; identify the ratio of consumers and professionals; determine mission and vision statements; and to develop by-laws to include terms of members, officers needed, voting requirements, executive board members, quorum delineation, and compensation of members.

The MPCA will seek technical assistance from Georgetown University to assist in strengthening culturally competent practices. Technical assistance is requested to enhance the capacity of MPCA to reach the culturally and linguistically diverse individuals in the underserved communities. MPCA plans to utilize the expertise of Georgetown University's National Center for Cultural Competence to develop a conceptual framework and definition for cultural and linguistic competence, identify the need for cultural and linguistic competence, develop policies to promote and sustain cultural and linguistic competence, and develop tools to assess the cultural and linguistic competence of MPCA and its community partners. //2008//

/2009/ Mary Frances Kornak, MPH, will be responsible for the day to day management of Title V activities. Reporting to the Title V Program Coordinator, Ms. Kornak will assist the Program Coordinator in the Title V grant implementation and monitoring of compliance; respond to queries from HRSA related to DOH Title V activities; responding to program staff and grantees related to Title V performance measures and proposed activities; assist with development of reports and presentations.

Ms. Kornak has more than 15 years experience in public health and medical field including protocol design and survey development; project analysis, management and evaluation; clinical and scientific writing and technical knowledge in computers. She earned her Bachelor of Arts from the College of Notre Dame of Maryland and Masters in Public Health from George Washington University.

Refer to Form 15.
MS Kornak is the lead contact person for additional information related to CHA request for technical assistance in the following areas:

1) To establish a Title V Maternal and Child Program Advisory Committee.
CHA will no longer be creating a new advisory board. CHA has decided to utilize the existing structure of the CSHCN Advisory Board. In the next few months the CSHCN-AB will be retailored to make full use of their expertise such as: 1) to review current state priorities, 2) to identify gaps

in services within the District's health care delivery systems, 3) to identify who in the community can best fill those gaps, 4) to monitor state performance measures and program progress and 5) and to ensure that Title V funds are spent appropriately and guide DOH to meet the needs of mothers, infants, and children, including children with special health care needs.

However, it would be prudent to get a facilitator to expand the composition of the CSHCN-AB; identify the ratio of consumers and professionals; evaluate mission and vision statements, review by-laws to include (terms of members, officers needed, voting requirements, executive board members, quorum delineation, and compensation of members). This person would facilitate growth; increasing parent participation. Increasing active members including youths will help the board thrive beyond what exists today, and also helps CHA immensely to monitor our response to the cities problems.
CHa will look to HRSA to name a vendor/identify resources.

2) To assist in strengthening culturally competent practices. Technical assistance is requested to enhance the capacity of CHA to reach the culturally and linguistically diverse individuals in the underserved communities. A suggested vendor is Georgetown University's National Center for Cultural Competence who has the expertise to develop a conceptual framework and definition for cultural and linguistic competence, identify the need for cultural and linguistic competence, develop policies to promote and sustain cultural and linguistic competence, and develop tools to assess the cultural and linguistic competence of CHA and its community partners.

3) To assist CHA to build population based strategies for implementing Maternal and Child programs.
The District's health disparities are higher in specific wards however, infant mortality, childhood obesity, asthma, youth violence, lead issues and oral health affect significant numbers of District residents in variouis wards. DOH seeks assistance in identifying population based strategies that meet the needs of the District as a whole. DOH requests that HRSA make a recommendation on who would be the best technical advisor/identify resources.

4) To assist CHA build evaluation capacity within the DOH. As DOH moves toward increased program funding and oversight and management of awarded community based grants and contracts it seeks assistance in developing capacity within DOH to effectively monitor awards. Bureau staff work closely with grantees and need tools to guide and counsel awardees to ensure compliance with the scope of work, performance measures and expected outcomes. CHA will look to HRSA to identify a vendor/resources.

5) To assist in the development of performance measures for evaluation tools as a component of the grants management process, specific to Maternal and Child programs. DOH is focused on increased program focused allocation of funds with DOH oversight and management of awarded grants and contracts. Therefore it seeks assistance in developing performance measures that support proposed outcomes and ensures appropriate distribution of funds. CHA requests HRSA make a recommendation/identify resources.

6) To assist CHA with a review of the District's strategies that focus on decreasing youth violence and injury and assist DOH in selecting evidence based strategies that serve the District's targeted population as well as assist with defining the processes required for implementation and performance based evaluation methodologies CHA will look to local resources such as American Acadmy of Pediatrics and other existing youth violence programs.
//2009//

/2010/ CHA received technical assistance for an organizational assessment of the CSHCN Advisory Board. Dr. Michela Perrone was contracted to design the survey form in order to address the following:
1) Evaluate the Board's operation and member representation in terms of the effectiveness

of the Board to carry out its mission;
2) Clarify the relationship between the Board and CHA in terms of its mutual expectation;
3) Determine the development needs of Board members; and
4) Identify the optimum strategies to meet the mission and purpose of the Board.

The technical assistance scope of work also included 1) development of a performance rating tool for determining board effectiveness and 2) exploration of establishing the Board as a 501c(3) organization. The Board decided not to pursue organization as a 501c (3) entity.

The assessment survey was distributed on June 15. A summary of member responses was presented during the June 30th Board meeting. The Board member comments and recommendations included: 1) provide consistent board member education and development; 2) need to develop a strategic plan; and 3) the continued need for CHA and DOH participation and staff support.

See attached summary of results. The board met in July to develop a strategic plan for the next 3 years that would include:

Other activities for 2009 included: classes on developing sub grant performance metrics and evaluation criteria.

The technical assistance needs for the 2010 grant year include:

1. Developing strategies to evaluate child deaths in DC.

2. Review exisitng strategies and identifying the best method to prevent second pregnancies in DC.

3. Evaluate service and program capacity for children with special health care needs.

4. Develop measures for the DOH and collaborative members to gauge and increase parent self-advocacy.

5. Develop an strategies to implement the Katy Beckett waiver for emergency care funding for DC residents.

6. Identify and develop data integration strategies.

7. Evaluate current methods versus a public health perspective to decrease youth viiolence.

//2010//

An attachment is included in this section.

V. Budget Narrative
A. Expenditures
V. Budget Narrative

A. Expenditures

/2008/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

The percentage of Maternal and Primary Care Administration funds expended on the core services depicted by the four tiers of the MCH pyramid is as follows:

1. Direct Health Care Services (Basic Health Services and Health Services for CSHCN - 16%.
2. Enabling Services - 18%.
3. Population Based Services - 46%.
4. Infrastructure Building Services - 20%.

Maintenance of Effort/State Match

The District of Columbia expended $8,849,391 in state funds in providing services to the Title V population. This amount is $3,561,391 in excess of the $5,288,000 MOE requirement and$3,352,915 in excess of the $5,552,915 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools. //2009//

The District of Columbia will continue to expend Title V funding to support the following efforts:

-Adolescent Health Initiative
-Community-Based Teen Pregnancy Prevention
-Newborn Hearing Program
-Transportation Services
-Health Education
-Oral Health Services
-Infant and Child Mortality Review
-Early Intervention Programs
-Case Management and Care Coordination
-Men's Health Initiative
-Sickle Cell Initiative
-Genetics Program
-Newborn Metabolic Program
-Lead Poisoning Prevention Program
-Immunization Initiative
-SIDS and Infant Death
-Dental Sealant Initiative
-School-Based Health Centers
-Breastfeeding
-Medical Homes Initiative
-Women's Health Initiative
-Vision Screening

Other sources of Federal MCH dollars include:

-Eliminating Disparities in Perinatal Health
-Universal Newborn Hearing Screening
-District of Columbia State Systems Development Initiative
-Awareness and Access to Care for Children and Youths with Epilepsy
-Rape Prevention and Education
-Early Childhood Comprehensive Systems

Methodology: The State makes every effort to use the data collected by the Department of Health and other entities to direct MCH funds to address unmet needs. On a quarterly basis the Maternal and Family Health Administration proportions

program expenditures to reflect percentage of effort in
direct health care services, infrastructure-building, population-based services and enabling services. Program expenditures are also proportioned based on
the "30-30-10" earmarking requirement of Title V. //2008//

/2009/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

The FY2007 Award $7,583,387.46

The percentage of FY07 earmarking requirements included:

30% children with special health care needs: $2,275.016.24

YTD Personnel Services	$1,401,890.31
YTD Non personnel services	$ 888,103.64
Total expenditures	$2,289,993.95

Earmarking requirements 100.66%

30% FY2007 Preventive and Primary Care Earmarking $2,275.016.24

YTD Personnel Services	$1,208,428.08
YTD Non personnel services	$1,106,576.40
Total expenditures	$2,315,004.48

Earmarking requirements 101.76%

10% Administrative threshold $758,338.75

YTD FY07 expenditures on administration $283,663.63

% of FY07 Administrative threshold 37.41%

//2009//

/2010/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

The FY2008 Award $ 7,091,016

The percentage of FY08 earmarking requirements included:

30% children with special health care needs: $ 2,127,305

YTD Personnel Services	***$1,383,522***
YTD Non personnel services	***$ 779,282***
Total expenditures	***$ 2,162,805***

Earmarking requirements 30.5%

30% FY2008 Preventive and Primary Care Earmarking $ 2,127,305

YTD Personnel Services	***$ 1,629,342***
YTD Non personnel services	***$ 697,021***

Total expenditures	***$ 2,326,363***
Earmarking requirements	***33%***
10% Administrative threshold	***$ 709,101***
YTD FY08 expenditures on administration	***$ 681,676***
% of FY08 Administrative threshold	***9.6% //2010//***

B. Budget

V. Budget Narrative

A. Budget

/2008/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

EARMARKING REQUIREMENT

I. Preventive and Primary Care Services
The District of Columbia will continue to expend Title V funding earmarked for preventive and primary care on immunization, SIDS and infant death counseling, lead poisoning prevention, case management and care coordination, school-based wellness center, hearing screenings and genetic testing and counseling.

II. Services to Children with Special Health Care Needs
Title V funding is used to support the Children with Special Health Care Needs Bureau activities and programs and services through sub-grants. These programs and services address newborn hearing and metabolic screening, genetic services, sickle cell and medical and dental services to students attending two District of Columbia schools specifically for children with special healthcare needs.

III. Administrative
Administrative costs in the Department of Health and the Maternal and Primary Care Administration include administrative overhead, internal accounting and information system charges, budgeting, and other charges generated from the operations and management units of the operating division.

IV. Maintenance of Effort/State Match
The District of Columbia has allocated $10,758,179 in state funds to provide MCH services to the Title V population. This amount is $5,470,179 in excess of the $5,288,000 MOE requirement and $5,439,917 in excess of the $5,318,262 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools, teen pregnancy prevention, Women Infants & Children / Commodity Supplemental Food Program and Immunization Campaign. //2008//

/2009/ The DOH allocates Title V funding according to the defined categories described in the Application Guidance: 30% for preventive and primary care services for children; 30% for services for children with Special Health Care Needs; 30% for planning, administration, evaluation and education; and 10% for grant administration. The following presents the budget narrative to support personnel; programmatic and other related expenses.

Personnel Budget Narrative $3,453,123.58

The proposed personnel budget includes program, administrative and support staff positions described below. The total salary costs are $2,928,858 plus fringe benefits (.1794) in the amount of $524,265.58. The total personnel budget is $3,453,123.58. Title V funding supports 49.5 FTEs.

Title V fund allocation for staff is limited to the Administration (30%), Primary Care and Prevention (30%) Child Adolescent and School Health Bureau and (30%) for Special Health Care Needs Bureau.

Bureau Chief
Epidemiologist
Executive Assistant
Grants Management Specialist
Investigator
Program Analyst
Program Specialist
Project Coordinator
Public Health Advisor
Public Health Analyst
Receptionist
Research Analyst
Statistical Assistant

Non Personnel Budget Narrative - $3,262,750.00

DOH proposes the following funding allocations for the various maternal child programs. CHA will earmark funds in accordance with the Title V Block Grant allocations requirements: Primary Care and Prevention Funds (30%); Children with Special Health Care Needs (30%); Other (Planning, Administration, Education and Evaluation) and 10% for Grant Administration.

Health Babies Project Program was awarded in 2008 and is focused on health risk prevention in targeted Wards 5, 6, 7 and 8. The Project will collect, monitor and report health risks and mitigation strategies. CHA expects to exercise Option 1 year funding in the amount of $248,000.

MOM Call Center is a Title V reporting requirement. Due to centralization of all District call centers, the 1-800-MOMs call has been absorbed into the central call center. Residents call either the 1-800-MOM number or the 311 number to obtain needed information. In order to track the specific calls related newborns and mothers software adaptation is required. Funds in the amount of an estimated $45,000 will be allocated to the call center vendor to track data that meets the Title V reporting requirements.

PRAMS Like Survey will focus on capturing data on pregnancy and barriers to prenatal care based on the Pregnancy Risk Assessment Monitoring System (PRAMS) model. It is expected to be a population-based risk factor surveillance system designed to identify and monitor selected maternal behaviors that occur before and during pregnancy and the child's early infancy. CHA will issue a Request for Proposals to a vendor to provide the survey services in the amount of $30,000.

Advisory Board comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities. Membership includes DOH and National Institute of Child Health and Human Development (NICHD), health care providers, managed care companies, and community-based organizations. Funds will be used to support the organization, logistics and facilitation of Advisory Board meetings. CHA will issue a Request for Proposals to a vendor to provide the services in an estimated amount of $15,000.

Youth Violence and Injury Program will focus on identification and implementation of strategies to mitigate youth violence and injury among high risk youth. A Request for Proposal will be issued and program fund allocation in the amount of $250,000.

Rand Study -- Assessment of the School Nurse Program to focus outcomes of school based health activities. An estimated $250,000 is allocated for this effort.

Expansion of the Pregnancy Prevention Program to decrease teen pregnancy and support health life styles. CHA allocates an estimated $100,000 for this program.

Transition Case Management Program is expected to support the transition of children with special health care needs to adult services through a case management program. A Request for Proposal will be developed and issued for a qualified community based organizations. An estimated award in the amount of $500,000 will be awarded to a qualified vendor.

Family Development Center for children with special health care needs provides parent child classes. CHA may exercise Option 1 year of the two year grant in July 2009. The estimated award of the Option 1 year funding is $38,000.

Oral Health Program -- funding to support oral health education in the DC Public Schools and Charter Schools; pregnant women's oral health, school nurse oral health education as well as efforts to enhance provider participation in Medicaid management care programs and oral health policy development. An estimated $125,000 will be allocated to support expansion of the oral health initiatives in DC Public and Charter Schools.

CHA will continue to support the efforts of the Epilepsy and Seizure Disorders program including development of treatment protocols and primary care provider notification for use by emergency room staff when a child presents with a seizure. An estimated funding in the amount of $30,000 will be allocated to the Epilepsy Learning Collaborative.

Autism Program to enahnce capacity to improve parents and caregivers access to autistic spectrum disorder services. An estimated $100,000 is allocated for this project.

Parent Information Network project expansion from a family navigator pilot project to implementation phase. The scope of work will include expansion of navigation services to families with children with special needs; help desk, or resource directory of state and regional services for children with special health care needs. The option year under the current contract may be exercised in an estimated $500,000.

The Lead Program will provide blood lead level screening for uninsured children. A proposed budget of up to $50,000 is allocated to support laboratory and related expenses.

To support the Child Health Action Plan target to enhance the care and services to children with asthma, it allocates an estimated $100,000 to development of the Quality Improvement Initiative and best practice and evidence based protocols for children with asthma.

Block Grant Meetings staff expenses in the amount of $3,000 as required in the Application Guidance. The funds will be used for staff expenses related to travel and lodging to attend HRSA and other MCH meetings.

Title V Staff Training in the amount of $30,000 will be used to support the professional development of program staff.

Town Hall Public Input meeting logistics and facilitation to enhance public input opportunities related to the goals and objectives of the Title V Maternal and Child Health Block grant. A vendor

will be identified to provide facilitation and logistical services. Proposed allocation of funds is $5,000.

Professional development sub grant to a qualified a vendor to provide continuing education programs related to MCH services, data collection, analysis and integration and other relevant programs. An estimated $30,000 is allocated for the grant.

Need Assessment -- a Request for Proposals will be issued to develop the Title V Block grant requirement to conduct a needs assessment every five years. The scope of work will include but not be limited to a gap analysis; strengths and weaknesses of current MCH programs and services; community focus groups; development of the state priorities for future years. An estimated $300,000 will be allocated for this effort.

Grant writers to support development of grants to support maternal child health activities as well as assist with the development of the Needs Assessment. The proposed allocation of fund is $100,000.

Data Integration Project is a critical program to facilitate the linkages of health and surveillance data from disparate applications. Utilizing an enterprise architecture approach and a master patient index CHA will integrate eight program applications. Cost per program implementation is $120,000 each. Project estimated cost is $960,000.

OCTO Contract for information technology maintenance services includes help desk support and trouble shooting for technology issues. Costs are estimated at $750 per year time for an estimated 50 personal computers = $33,750.

Maintenance of Effort/State Match

The District of Columbia expended $8,849,391 in state funds in providing services to the Title V population. This amount is $3,561,391 in excess of the $5,288,000 MOE requirement and$3,352,915 in excess of the $5,552,915 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools. //2009//

B. Budget

/2010/ The DOH allocates Title V funding according to the defined categories described in the Application Guidance: 30% for preventive and primary care services for children; 30% for services for children with Special Health Care Needs; 30% for planning, administration, evaluation and education; and 10% for grant administration. The following presents the budget narrative to support personnel; programmatic and other related expenses for 2010.

Personnel Budget Narrative $5,170,378.00
The proposed personnel budget includes program, administrative and support staff positions described below. The total salary cost is $5,170,378.00 and includes fringe benefits (.1794). The total personnel budget is $5,170,378.00, supporting 64.5 FTEs.

Title V fund allocation for staff is limited to the Administration (30%), Primary Care and Prevention (30%) Child Adolescent and School Health Bureau and (30%) for Special Health Care Needs Bureau.

Chief, Office of Grants Management
Administrative Officer
Epidemiologist

Executive Assistant
Grants Management Specialist
Program Analyst
Program Specialist
Project Coordinator
Public Health Advisor
Public Health Analyst
Receptionist
Statistical Assistant

Non Personnel Budget Narrative - $2,046,578.00

CHA proposes the following funding allocations to support the objectives of the Title V grant.

1) $250,000 School Nurse Integration: - Expansion of School Nurse Services (RAND Part II)

The second phase of the RAND School nurse survey will focus on the expansion of health services performed by the school nurse for children with special health care needs including children with chronic health conditions improving student case management and comprehensive care through integration of the nurse as a vital component of the care team.

Long-term chronic medical conditions such as asthma, anemia, diabetes, hemophilia, epilepsy, and leukemia have heightened the need for population based health promotion, prevention, and early intervention services in school settings. Achieving this comprehensive coordination of care will be accomplished by working with the school nurses to:

a). develop a set of practice standards for nurses to ensure that children with special health care needs and those with chronic health conditions are receiving optimal health care oversight while in school
b). develop a coordinated care plan in partnership with school personnel, parents, and the child's primary care provider
c). Develop protocols that will focus use technology assistance, medication and treatment administration, and supplemental nutrition that must be addressed while the child is away from home and at school.

2) $100,000 Autism and Asperger's Syndrome
Develop contract to determine the true number of autism cases in DC and enhance capacity to improve parents and caregivers access to support services.

3) $100,000 Childhood Obesity
Supplement local funds to reduce childhood obesity.

4) $220,000 Pregnancy Prevention Programs
Second year funding that focuses on teen pregnancy prevention and support healthy life styles

5) $250,000 Transition Case Management Program (National Alliance to Advance Adolescent Health)
The program is expected to support the transition of children with special health care needs from pediatric to adult services through a case management program.

6) $250,000 Continue Parent Information Network (Advocates for Justice)
The scope of work will include expansion of navigation services to families with children

with special needs; provide referrals to parent support, home education, and paretns skills training; develop a help desk, or resource directory of state and regional services for children with special health care needs.

7) $50,000 Epilepsy Program
Continue funding of the Epilepsy Foundation to provide referral and navigation serivces to youth with epilepsy and provide leadership activities for youth and paretns to be educated participants in their child's healthcare.

8) $125,000 Youth Violence Prevention Program (Edgewood/Brookland Collaborative)
Continue funding to address mitigation strategies related to youth violence.

9) $250,000 Title V Needs Assessment (Intergroup Services)
Title V Block grant requirement, to conduct a needs assessment every five years. The scope of work will include but not be limited to a gap analysis; strengths and weaknesses of current MCH programs and services; community focus groups; development of the state priorities for future years. The award will include any logistics or expenses from facilitation of the Town Hall Public Input meeting.

10) $250,000 Continued funding of the Healthy Babies program.

11) $5,000 -- HRSA and other MCH Meeting - staff expenses as required in the Application Guidance. The funds will be used for staff expenses related to travel and lodging to attend HRSA and other MCH meetings such as the AMCHP annual conference

12) $1,000 -- Payment for up to 3 members of the CSHCN Advisory Board to attend the AMCHP conference. CHA will determine eligibility based on need and willingness to provide presentations to the advisory board.

13) $10,000 Purchase of LeadCare 2 test kits for the lead program (2 -- 1 for the Lead Mobile, 1 for indoor use at health fairs), and for each health clinic, so that they could do CDC-approved blood lead tests on the spot, without having to send families to labs.

14) $75,000 The Lead Program will issue a request for proposal to conduct an independent water analysis for lead. An estimated $250,000 is needed for this unfunded mandate. However, Title V will allocate $75,000 to support laboratory and related expenses.

15) $30,000 Title V Staff Training used to support the professional development of program staff.

16) $33,750 OCTO contract for information technology maintenance services includes help desk support and trouble shooting for technology issues. Costs are estimated at $750 per year time for an estimated 50 personal computers

Any additional funds will be used to cover added expenses including non solicited proposals.

Maintenance of Effort/State Match
The District of Columbia expended $10,144,404 in state funds in providing services to the Title V population. This amount is $4,856,404 in excess of the $5,288,000 MOE requirement and $4,844,404 in excess of the $5,304,000 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools. //2010//

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.